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ABSTRACT

This monograph reflects the writings, discussions, and recommendations of the Switzer Scholars at the 16th annual Memorial Seminar. Introductory materials include the following: "A Tribute to Mary E. Switzer"; "Welcome from the National Rehabilitation Association" (Spencer L. Mosley, Ann Ward Tourigny); list of seminar sponsors; "Introduction" (Leonard G. Perlman, Carl E. Hansen); and photographs of the 1993 Switzer Scholars. The five papers written expressly for the seminar follow: "Development of Rehabilitation in Business and Industry: Implications for Rehabilitation Counselor Training" (Ralph M. Crystal); "Educating Practitioners for Work in the Private Sector" (Dennis David Gilbride); "Insurance Issues and Trends: A Focus on Disability Management including Rehabilitation" (Patricia M. Owens); "Trends and Innovations in Private Sector Rehabilitation for the 21st Century" (John W. Lui); and "Ethical Issues in the Private Sector" (Edward P. Steffan). Four special invited papers are included: "The History of Private Sector Rehabilitation" (Lloyd M. Holt); "Choice, Autonomy, and Individual Provider Selection" (Stephen A. Zanskas); "Rehabilitation in Workers' Compensation: A Growth Potential" (Bruce Growick); and "Rehabilitation in the 90's and Beyond" (Barbara Greenstein). A brief biography of Mary E. Switzer concludes the monograph. (YLB)

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Switzer Seminar Series *October 1993*

ED 368 860

Private Sector Rehabilitation: Insurance, Trends & Issues for the 21st Century

A Report on the 17th Mary E. Switzer Memorial Seminar

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A Tribute To Mary E. Switzer

by a Friend & Colleague

We are pleased to report that Col. McCahill received an Honorary Switzer Scholar award at the reception honoring the Scholars at this year's seminar. He was honored for his 50 years of service and dedication to persons with disabilities. He was also on the original planning committee to set up the Mary E. Switzer Memorial Committee of NRA in the early 1970's, and of course, he was a long time friend and colleague of Ms. Switzer.

The following are Col. McCahill's thoughts of Ms. Switzer, which he titled, *To an International Pilgrim in Rehabilitation.* In the December, 1971 issue of Performance, then the monthly magazine of the President's Committee on Employment of the Handicapped (PCEH), I wrote an In Memoriam of my friend and long-time co-worker, "Queen Mary."

By Col. William P. McCahill, Former (and first) Director of the President's Committee on Employment of the Handicapped, Executive Committee member and past Chairman, People-to-People Committee for the Handicapped.

I said in part that Mary was a familiar participant in gatherings abroad and near to home, and the Switzer Memorial Committee more than two decades later, is continuing these "gatherings" in her memory, serving persons with disabilities worldwide as she did for so long.

I also quoted her pastor in my article as saying in his eulogy, *May the good work begun in her be continued in those of you who remain.* As one of those who "remain" from 1946 to the present, I can testify that the Switzer Memorial Committee and NRA have nobly obeyed the charge of Mary's Minister in Alexandria. In my last short paragraph I said in part, "She has been all things to all people, serving those who served...She will stand out as a pilgrim of the last quarter century of rehabilitation." That she is indeed, and the Switzer Scholars and NRA leaders continue her pilgrim's progress.

But I want to emphasize her great and lasting contributions to international rehabilitation around the globe. She and I worked together at several Rehab International World Congresses where she would sit in the seats reserved for the USA, doing her perpetual knitting. When she left, I (for PCEH) would sit in her place, sans knitting.

Her P.L. 480 foreign research grants served as a two-way crossfertilization program, benefitting both the U.S. and overseas persons with disabilities.

She received the highest honors around the world wherever she went, including Rehab International's Winged Victory Statue, and the President's Committee Distinguished Service Plaque signed by a U.S. President. She brought countless foreign leaders to the U.S., in cooperation with the World Rehabilitation Fund and Dr. Howard Rusk, Rehabilitation International and many other international organizations. She was naturally in great demand as a keynote speaker. At one international meeting

Col. William P. McCahill talks to Switzer Scholars and guests after receiving the Switzer Scholar award at the reception in Washington, D.C

in Canada she had to send regrets the day before her presentation and I went to my hotel room with a borrowed typewriter and crafted a reasonable substitute speech. I was first a journalist before becoming a marine, a bureaucrat and, at present at age 77, the newest Switzer Scholar.

Our international trips weren't all business, but provided fun and games and a chance to exchange ideas and to cement friendships with peers. And,at each PCEH annual meeting, our dias, both tiers, was filled with distinguished foreign leaders who utilized opportunities while in the U.S. to meet with Mary both socially and professionally. I never saw the many letters that poured in from abroad after her death, but then RSA Commissioner Joseph Hunt and friend Isabel Diamond answered most of them.

During the 50's and 60's Washington and the U.S. Congress were male dominated, but she strode the Halls of Congress getting her way with hardly a murmur of dissent from Sen. Lister Hill and Rep. John Fogerty who chaired the Appropriations Sub-committees. Like those who remain, and too many who are missing, we all had wonderful stories of Mary. But, that's another article.

One last quote from my Performance Memoriam: "Each of us who knew her will cherish her memory, for many reasons, for things said and unsaid, deeds done and undone. This the Switzer Memorial Committee, the NRA and the Switzer Scholars are doing in keeping her memory alive. And, for that, a Marine Colonel's salute of gratitude and praise. She too, was Semper Fidelis.

Private Sector Rehabilitation: Insurance, Trends & Issues for the 21st Century

National Rehabilitation Association
633 South Washington Street
Alexandria, Virginia 22314
VOICE (703) 836-0850
TDD (703) 836-0849
FAX (703) 836-0848

Editors
Leonard G. Perlman
Carl E. Hansen

Director of Communications
Ronald J. Acquavita

1993 Switzer Scholars
Catherine C. Bennett
Phillip Bussey
Ralph M. Crystal
Estelle Davis
Tom Davis
Tim Field
Juliet H. Fried
Dennis Gilbride
Barbara Greenstein
Bruce Growick
Jeanine Johnson
John W. Lui
Patricia Nunez
Patricia M. Owens
Jeffrey J. Peterson
Ed Steffan
Dora Teimouri
Daniel M. Thomas D.C.
Mary Vencill
Jackie Wilson
Stephen Zanskas

The *Switzer Monograph* reflects the writings, discussions and recommendations of the Switzer Scholars at the 16th Annual Mary Switzer Memorial Seminar, held June 2-4, 1993, at the President's Committee on Employment of People with Disabilities in Washington, D.C. Opinions expressed in the *Switzer Monograph* are those of the writers and do not necessarily reflect policy of the National Rehabilitation Association or any other organization.

The National Rehabilitation Association is a non-profit organization dedicated to improving the quality of life for people with disabilities.

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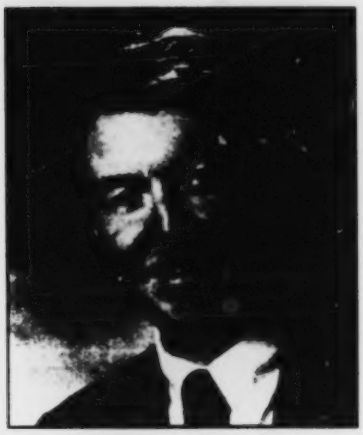
Welcome from the National Rehabilitation Association



Spencer L. Mosley
President,
National Rehabilitation Assn

1993's Seventeenth Mary Switzer Memorial Seminar Topic - "private Rehabilitation", continues this Seminar's tradition of addressing important contemporary subjects within the rehabilitation arena. Representative of the change that is constant in our field, private practitioners can provide options for people with disabilities that offer a unique alternative, or solution, to their rehabilitation problems.

As a comparatively new partner within the rehabilitation community, private rehabilitation shares in the increasingly more complex business of providing evaluative assistance, vocational direction and employment alternatives to persons with disabilities seeking jobs and independence.

We know that the creative and insightful efforts characterized by the developments and products of private rehabilitation will further expand the array of services available to assist all of us in "enhancing the lives of persons with disabilities"!

Spencer L. Mosley

Ann Ward Tourigny
Executive Director,
National Rehabilitation Assn

The Mary E. Switzer Memorial Seminar holds a special place in the history and tradition of the National Rehabilitation Association. First, the Seminar honors a "grand lady" of rehabilitation. I wish I had known Mary Switzer. From her writings, biography, and stories relayed by those who did know her; I have developed a deep respect for both who she was and what she did. Second, the seminar serves as the leading edge of rehabilitation knowledge, policy, and practice. In addition, the Switzer Scholars represent the best minds in the field, and this monograph synthesizes the current state of the art on private sector rehabilitation.

The National Rehabilitation Association is proud to sponsor the seminar. I was honored and pleased to participate in this, the seventeenth seminar. I pledge my personal support, and that of the organization, to transferring the knowledge brought forth in this document into practice.

Sincerely,

Ann Ward Tourigny, Ph.D., CAE

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The Seminar Sponsors

17th Mary E. Switzer Memorial Seminar and Monograph

The support of the following sponsors is deeply appreciated:

The Dole Foundation for Persons with Disabilities
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Austin, Texas

Charlotte Cohen & Associates
Brooklyn, Minnesota

RJR Nabisco, Inc.
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Athens, Georgia

The Seminar Host

Dear Reader:

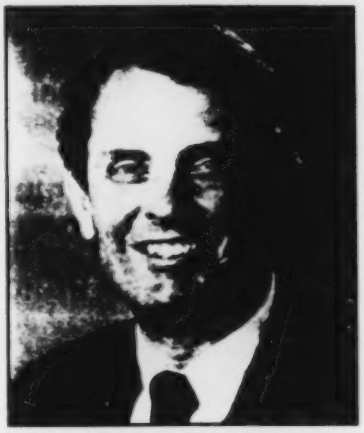
Once again, the President's Committee on Employment of People with Disabilities is proud to have been able to support another edition of the Switzer program.

This year's subject is especially important to all concerned with disability policy. The papers presented and the discussion that ensued on worker's compensation and issues of insurance offer tremendous insight into an area that needs to be better understood and managed. My compliments to both the planners and participants of this, the 17th edition of the Switzer Memorial Seminar, for a job "well done".

But, the story must not end here. The Switzer scholars' work represents a departure point, not an end result. It's up to the rest of us to take advantage of their scholarship and the scholarship of others and get involved in positive ways to help move the system forward so that people with disabilities are better served. Read the report and better define how you can play a part in this important challenge.

Rick Douglas

The President's Committee on Employment of People with Disabilities



Richard Douglas
Executive Director,
President's Committee on
Employment of People
with Disabilties

Acknowledgements

The 17th Mary E. Switzer Memorial Seminar and monograph of the proceedings were made possible by a number of people and organizations dedicated to the independence of people with disabilities.

Appreciation is expressed to the following: Rick Douglas, Executive Director, and Justin Dart, Jr. Chairman, President's Committee on Employment of People with Disabilities (PCEPD), the host of this year's Seminar, Paul Hippolitus, Director of Program (PCEPD); Spencer Mosley, President, NRA, Ann W. Tourigny, Executive Director, NRA, Ron Acquavita, Director of Communications (NRA), and the NRA staff who who assisted with the many details of the Seminar and Monograph.

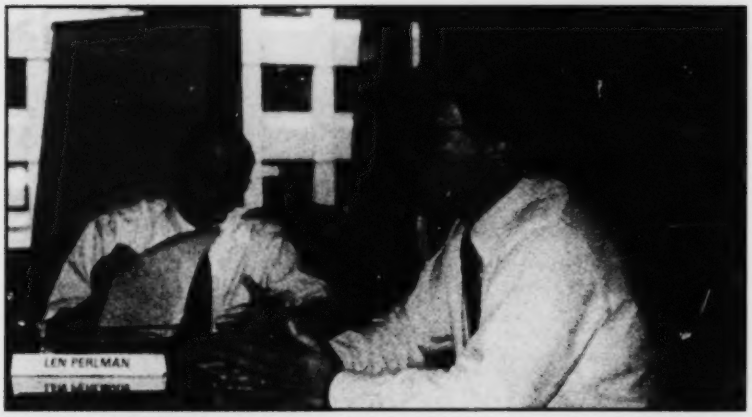
Gratitude is expressed to the Sponsors of the Seminar who helped make this memorial event a reality through their generosity.

Finally, our appreciation goes to the Switzer Scholars for giving so freely of their time and expertise and whose ideas are presented in this monograph. They have our admiration and thanks.

At the Seminar

The 1993 Mary E. Switzer Memorial Seminar Scholars

Carl E. Hansen, Chairperson, Switzer Memorial Committee, Ann W. Tourigny, NRA Executive Director, and Mark Shoob, Deputy Commissioner of RSA provide a welcome for the Scholars.



John Lui debates the issues on his paper *Trends and Innovations for Private Sector Rehabilitation.* Len Perlman, Switzer Seminar Coordinator is in the background

Committed to Enhancing the Lives of Persons with Disabilities

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Introduction

As I look back over the colorful, exciting, and productive years in rehabilitation, I tend to see the inspiration and accomplishments in terms of two kinds of people. First the pioneers, the leaders, those who conceived of a national, and, in fact, an international program that would deal with disability as a major cause of dependency and were pledged to do something about it. And second, the group of gallant individuals growing in numbers each year who through their own efforts, aided by the counselors and often by services of rehabilitation agencies and facilities, were able to conquer their disability, rise above it, and in many instances turn it into an asset or opportunity to go beyond where they would have been had they not had this tremendous victory to achieve.

Mary E. Switzer

Carl E. Hansen
Chairperson,
Mary E. Switzer Memorial
Seminar Committee

Leonard G. Perlman
Coordinator,
Mary E. Switzer Memorial
Seminar Committee

For the past eighteen years the Mary E. Switzer Memorial Seminars have kept the name of Ms. Switzer alive and have also become synonymous with innovative rehabilitation practices. The Switzer Seminars have provided a forum and think-tank approach to reviewing topics of major importance to the field of rehabilitation and the persons served by this profession. Each year a small number of persons (18-21) are drawn from experts and consumers with interests and accomplishments in the topic under consideration for the seminar.

The 17th Switzer focused on Rehabilitation in the Private Sector along with issues such as insurance, workers' compensation, etc.

The following excerpts of comments/recommendations made by Switzer Scholars help to set the tone for the seminar and indicate the scope of the types of issues generated by the chapters written expressly for the seminar.

"Counselors entering the private sector must understand the pressure that will be put upon them by purchasers of their services... Situations in real life issues imply that counselors must have the conviction to stand up for their ethical beliefs. With regard to training, not only should ethical standards be part of counselor training programs,curriculum design should allow students of counseling to know themselves and their ability to withstand pressures from outside influences.

– Estelle Davis

"Rehabilitation in the private sector has indeed experienced enormous growth and expansion since its inception in the late 1960's. The foundation for such a movement has clearly found its roots in the state-federal programs that had been in place for nearly seventy years. New funding sources, primarily the insurance companies for compensation programs, have required rehabilitation professionals to deliver services in new and innovative ways for returning the injured worker to jobs."

– Tim Field

"Rehabilitation education appears to be geared to produce professionals for the public sector. We need to ensure that we have a supply of qualified professionals for the private sector and need to address the funding of rehabilitation education and curricula to achieve this... We will see increasing diversity in the work force. One issue for rehabilitation will be the increasing need for bilingual or multilingual counselors. The aging work force will also create additional challenges in terms of the range as well as the nature of disabilities."

– Catherine C. Bennett

"It is vital that rehabilitation professionals pay particular attention to disability management. The effectiveness of rehabilitation programs depends on how well the rehabilitation counselors can provide services. State legislatures may not be inclined to continue worker compensation rehabilitation programs if the public is not being adequately served."

– Ralph M. Crystal

"The chapter by Dr. Gilbride discusses ne various opportunities that are available to rehabilitation personnel, experts in disability and work as it relates to the American's With Disabilities Act (ADA), life care planning, expert witness testimony, forensic work and 'disability management.' With these new roles and current changes, the roles of the paraprofessional and the rehabilitation professional needs to be clearly defined. The training needs of those working or planning to work in the private sector need to be incorporated into rehabilitation education programs."

– Jeanine C. Johnson

"Ms. Owens in chapter three suggests that there is an important role for rehabilitation professionals in disability management. Clearly, there is overlap between the mission of vocational rehabilitation and purpose of disability management. The field of rehabilitation needs to look closely at the type of skills and expertise it can provide to employers and insurers to facilitate reductions in injuries, prompt and effective medical and vocational rehabilitation, and swift return to work."

– Dennis Gilbride

Citing the ADA, Health Care Reform, Twenty-four hour coverage and Social Security Reform as four change-agents influencing disability management, Ms. Owens (in chapter three) identifies an unstable, concentrated and turbulent organizational environment. She correctly states that rehabilitation professionals can shape the field and the field of rehabilitation will be shaped by these agents of change...Perceptive rehabilitation professionals that efficiently observe, analyze, and process the changes in their environment will prosper. In a field already recognized for demands of accountability, the documentation of both "hard" and "soft" case management savings appears crucial."

– Stephen A. Zanskas

The above excerpts provide a rich cross-section of the ideas and critical issues discussed and debated at the three-day seminar. It is obvious that the debate of these issues will continue, hopefully stimulated by the information contained in this monograph of the 17th Switzer Memorial Seminar.

Our introduction ends with a quote by one of the Switzer Scholars. It is both a warning and a challenge with a strong suggestion of what the field of rehabilitation needs to do as we prepare for the 21st Century.

Our first task in planning for the next century should be to find out if we are at risk for even surviving, and if so, to what degree? Our planning, education, service delivery, and all the other elements that comprise what we presently think of as rehabilitation counseling as a profession will have to take these findings into consideration, but hopefully in a proactive and coordinated fashion in ways that will be new to us all... We are the beneficiaries of the work of the giants of our field, like Mary Switzer, persons who did not wait for the benefit of rehabilitation. That is our challenge, and one which I believe we must meet to assure our survival in the years to come.

– Phillip Bussey

It is the hope of the Switzer Scholars that the ideas and recommendations found in this report will be used to stimulate thinking and action as we strive to improve services to persons with disabilities.

Background and Purposes of The Switzer Memorial Seminars

The Mary Switzer memorial seminars, a program of the National Rehabilitation Association (NRA), is designed to bring together a small number of experts in the area of rehabilitation that is the focus of each year's seminar. The experts are designated as SWITZER SCHOLARS by certificate, and this recognition has become a significant and prestigious achievement for persons interested in vocational rehabilitation, both nationally and internationally. The end-product of the three-day program is a published monograph of the proceedings, including recommendations and implications for action in areas such as research, program and policy development, training and legislative needs. The format of the monograph is designed for ease of use by counselors, consumers, educators, policy-makers or anyone interested in the independence of people with disabilities.

The seminars are a living memorial to the late Mary E. Switzer, one of America's foremost leaders and trailblazer for innovative programs at the national, state, local and international levels for those persons with a disability.

The Switzer Memorial Committee of NRA was started by colleagues and friends of Mary Switzer, including key members of the U.S. Congress, Secretaries of the U.S. Department of Health, Education and Welfare, the Department of labor, private citizens and of course, NRA members.

The Current Switzer Seminar

The 17th Mary E. Switzer Memorial Seminar was held in Washington, D.C. on June 2-4, 1993, and was hosted this year by the President's Committee on People with Disabilities (PCEPD). Welcomes were provided by Justin W. Dart, Jr. Chairman, (PCEPD);Ann W. Tourigny, NRA Executive Director, Carl E. Hansen, Chairperson, Switzer Memorial Committee (NRA) & Mark Shoob, Acting Deputy Commissioner, Rehabilitation Services Administration (RSA).

Planning For The Seminar

The Switzer Planning Committee met in Washington, D.C. in early January, 1993 and developed the objectives of the 17th Switzer Memorial Seminar and provided the format and subtopics to serve as a foundation for the seminar. The subtopics served as a basis for the discussion and debate that have become the hallmark of the Switzer Memorial Seminars. The subtopics are now listed in the table of contents as chapters in this monograph. The chapters were sent in advance to the Switzer Scholars for their review, critique and preparation prior to the seminar. Selected comments and recommendations made by the Switzer Scholars are also found in this text. In addition, "Special Invited papers" are in the Monograph following the main chapters.

The Switzer Scholars

Catherine C. Bennett
Principal Financial Group
Des Moines, Iowa

Phillip Bussey
Bussey, Davis and Assoc.
Lanham, Maryland

Ralph M. Crystal
University of Kentucky
Lexington, Kentucky

Estelle Davis
Bussey, Davis and Assoc.
Lanham, Maryland

Tom Davis
Charlotte Cohen & Assoc.
Brooklyn Park, Minnesota

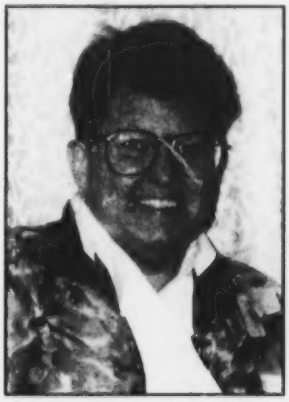
Tim Field
E & F Vocational Services
Athens, Georgia

Juliet H. Fried
Associate Professor-
Greeley, Colorado

Dennis Gilbride
Drake University
Des Moines, Iowa

Barbara Greenstein
UNUM Insurance Company
Tarrytown, New York

Bruce Growick
Ohio State University
Columbus, Ohio



Jeanine C. Johnson
Intracorp
Itasca, Illinois

John W. Lui
Rehabilitation Consultants,
Inc.,
Bedford, New Hampshire

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Patricia Nunez
Continental Rehab. Resources, Inc.,
Piscataway, New Jersey

Patricia M. Owens
UNUM Insurance Company
Brooklyn, New York

Jeffrey J. Peterson
Sulphur, Louisiana

Ed Steffan
EPS Rehabilitation Inc.
Tinley Park, Illinois

Daniel M. Thomas
Health Ins. Assn. of Amer.
Washington, D.C.

Mary Vencill
Berkeley Planning Assoc.
Berkeley, California

Jackie Wilson
Wilson Associates,
Montclair, New Jersey

Stephen A. Zanskas
Crawford & Co.
Green Bay, Wisconsin

Dora Teimouri
RSA/OSERS
U.S. Dept. of Education
Washington, D.C.

17th Mary E. Switzer Memorial Seminar Planning Committee

Phillip Bussey, Bussey, Davis & Associates, Lanham, MD
Ronald Conley, Pelavin Associates, Inc. Washington, DC
Estelle Davis, Bussey, Davis & Associates, Lanham, MD
Wesley Geigel, Electronic Industries Foundation, Washinton, DC
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Richard Lawrence, University of Maryland, College Park, MD
John Nelson, Rehabilitation Services Administration, Wash.,DC
Patricia Nunez, Continental Rehabilitation Resources, Inc.
Carl E. Hansen, Chairperson, Switzer Memorial Committee, Austin, TX
Leonard G. Perlman, Coordinator, Switzer Memorial Seminars, Rockville, MD
Ann W. Tourigny, Executive Director, NRA

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Chapter One

Development of Rehabilitation in Business and Industry: Implications for Rehabilitation Counselor Training

Ralph M. Crystal

The focus of the paper will encompass the development and growth of rehabilitation in business and industry with a particular emphasis on the implications for the training of rehabilitation counselors. The first part of this manuscript includes an overview of the development of rehabilitation in business and industry. The second part of the paper will present an examination of issues regarding worker compensation and business and industry as these relate to the training of rehabilitation counselors.

Historical Origins

Pressures to develop worker compensation programs increased with the shift from an agrarian to an industrial society in the late 1800s. Prior to this time the family and the extended family were viewed as the social support network. With the move from farms and rural areas to cities, the family structure was less able to provide for the needs of its members, particularly those who became incapacitated through injury, disease, or disability. The growth of industries and cities led to urbanization and a shift in the support system from the family to the community at large.

Before worker compensation laws were passed an injured worker had to prove employer negligence before being able to obtain medical services and financial relief. A civil lawsuit could be an expensive and drawn out process for an injured worker. The ability of an employee to win a civil lawsuit was reduced because of (a) possible contributory negligence, (b) negligence of a Co-worker, and (c) the assumption of inherent risks in a job. However, ultimately the social concern for an injured worker lead to the passage of worker compensation legislation.

The legal principle of worker compensation is liability without fault. The costs of work related injuries were to be allocated to the employer not because of presumed fault, but because of the inherent risks in industrial employment. White (1983) describes the purpose of worker compensation to "help workers survive the economic effects of work accidents and at the same time limit the financial liability of employers for those accidents" (p.59). Sink and Field (1981) state that worker compensation laws were designed to provide employers immunity from prosecution.

Workers compensation evolved as a program developed and administered by individual states. The federal government has also developed a rehabilitation program which covers federal employees. This is in contrast to the public rehabilitation program which is supported by national legislation and public tax monies, and is similar throughout the nation. Worker compensation developed as an individual state program and is viewed as a program that is best managed at the state level to respond to individual circumstances in each state. For example, differences in states call for different types of worker compensation programs.

States that have large populations and industrial bases have different needs than do states with small populations and an agrarian and service industry base. Therefore, worker compensation rehabilitation developed in response to local state issues. Also at the state level local industries, businesses, and labor unions can have a greater voice in worker compensation legislation than at the national level.

Despite differences in worker compensation programs all have certain common themes. According to Weed and Field (1986) these include the following: (a) to provide prompt and reasonable income and medical benefits for

Ralph M. Crystal, Ph.D., CRC, Prof., Rehabilitation Counseling Program, University of Kentucky, Lexington, Kentucky.

work related accidents regardless of fault, (b) provide a single remedy and reduce court delays, costs, and work loads arising out of personal injury litigation, (c) relieve public and private resources of financial drains, (d) eliminate payment of fees to lawyers and witnesses as well as time consuming trials and appeals, (e) encourage maximum employer interest in safety and rehabilitation, and (f) prompt the study of causes of accidents rather than concealment of fault.

Rehabilitation is included among the intentions of worker compensation legislation. White (1983) describes this benefit as designed to aid the partially disabled employee in finding a new trade or vocation so that he/she can again be a productive citizen. Although vocational rehabilitation is among the original goals of worker compensation, many states still do not mandate or provide for the vocational rehabilitation of injured workers (Weed and Field, 1986).

Another line of development in proprietary rehabilitation programs relates to the inclusion of long term disability provisions as a benefit of employment. With only a few exceptions, all employers are required to maintain worker compensation coverage for their employees. With long terms disability there is no such requirement. Typically, larger employers are more likely to offer a long terms disability benefit as a past of the employee benefits package. Long term disability coverage is for non-work related disabling health problems.

With this type of policy, the incentive to return a worker to employment is to minimize the costs associated with payments for disability when the covered individual is not working. This is especially the case if the individual is unable to perform his/her prior work because of the limitations resulting from the impairment. From the perspective of the insurance company it is to their advantage to return the worker to employment so benefits can be discontinued. The benefits and coverage of this type of insurance will vary from policy to policy. Although insurance of this kind is regulated in general by each state, the specific benefits and limits of the coverage is not.

Another area of disability benefits relates to personal injuries such as might occur through automobile accidents and slip and fall injuries. In many instances obtaining rehabilitation benefits requires the injured individual to go through a litigation process. With both personal injury and long term disability the advantage returning the injured person to employment can result in reduced costs with regard to lost wages and future power of the impairment to earn money. The defense in a litigation can make a stronger case for minimal wage and even future medical damages if the injured individual is working rather than sitting at home.

The Development of Proprietary Rehabilitation Programs

The rise of proprietary rehabilitation programs is closely linked to the concept of return to work programs. In the late 1960s insurance companies began developing and utilizing private rehabilitation companies to assist with medical case management and vocational rehabilitation programs. Insurance companies discovered that these private firms could reduce costs to the company because of their emphasis on getting the employee back to work as soon as possible. A return to the same job, or short term retraining and direct job placement in the same or similar job was emphasized.

In 1970 the Federal Occupational Safety and Health Act (PL-596) was passed. In addition to its other provisions, this legislation called for the creation of a National Commission on State Worker's Compensation laws. Several recommendations related to emphasizing vocational rehabilitation were included. Conley and Noble (1978) note that a federal interdepartmental policy group was formed to study the recommendations. Again, vocational rehabilitation was given a strong emphasis.

Lynch, Lynch, and Beck (1992) observed that skyrocketing medical and compensation costs to injured workers and expenses related to catastrophic injuries have spurred insurance companies and employers to review possible ways to contain costs and to have more control over rehabilitation outcomes (particularly return to work). Some large corporations have responded with extensive safety programs, employee support services, on site medical management, health promotion, and case management services.

These same factors have led to the development of proprietary practice in other areas of insurance. Thus, rehabilitation professionals now work in personal injury case, automobile accidents, and long term disability. It is not uncommon for rehabilitation professionals to be involved with a variety clients from different types of insurance. In fact, any time an issue of a persons' employability is raised the rehabilitation professional may be called upon to render an opinion.

Another factor that has led to the growth of the private rehabilitation sector has been the emphasis in the public rehabilitation program on clients with severe disabilities. Public programs emphasize developmental disabilities, transition, supported employment, and independent living. While the goals of public and private programs are similar, the procedures and techniques utilized are different. In fact, in many instances these two programs work together to serve clients. This cooperative planning has been utilized to facilitate the ultimate return to work potential for the client.

In public rehabilitation programs many clients have developmental disabilities or disabilities that develop with a gradual onset. This is in contrast to worker compensation rehabilitation where the primary disabilities relate to back, hand, and knee impairments. Pain is frequently a component of an injured workers' disabling condition. These types of injuries are also common in personal injuries and on occasion with long term disability.

Similarities and Differences Between Proprietary and Public Rehabilitation

In general the goal of proprietary rehabilitation programs is to help the individual return to a prior or related level of vocational, physical and/or mental functioning. This may also include monetary payments to compensate for lost

physical function and lost wages. This is similar to the insurance concept of replacement of value as occurs in other forms of insurance such as automobile, homeowners, and business policies. The person who incurs a loss in either worker compensation or other forms of insurance is entitled to a replacement for that loss either through a similar item (another car if one was totaled in an accident, or a job in worker compensation), or a cash payment (if an item cannot be replaced such as stolen jewelry).

The concept of worker compensation is similar to other forms of insurance in that a person is not entitled to an item of greater (or lesser) value than the one that was lost. So if a person has an automobile accident, that individual is entitled to an automobile of a similar value. If a person has a work injury he/she is entitled to another job (comparable to the prior job), or if that does not not occur than monetary payment to compensate for the value of the function that was lost is provided.

This is in contrast to the public rehabilitation program. Clients served by public rehabilitation programs are evaluated to determine the most appropriate rehabilitation outcome regardless of past employment or experience. This has been translated to mean asssiting the client to attain his/her full potential considering the resources of the agency and a reasonable expectation for success.

Although not intended, worker compensation programs can become adversarial. For example, there can be disagreements regarding the entent of disability of an injured worker as well as the contribution of pre-existing factors to the disabling condition. In public programs there is not typically disagreement reagrding the medical and psychological condition. In worker compensation program it is typical to have several medical, psychological, or vocational reports. Often these have contradictory conclusions. It is unusual in public rehabilitation to have a diversity of reports.

In many instances clients in public programs do not have a work history. In all instances clients in worker compensation and long term disability programs have been employed. It is not uncommon for a worker compensation client to have worked for many years at a manual labor occupation. When the injury occurs it may be difficult for the person to return to the job because of a sense of being worn out, even after the person has recovered medically to the injury.

Worker compensation clients frequently want to be compensated for their injuries and loss of function prior to participating in a rehabiltation program. In some instances the injured worker feels that he/she is disabled and unable to work and is uncertain why vocational rehabilitation is being undertaken. It is the exception in the public rehabilitation program not to want the services being offered. This is not to be confused with resistence on the part of the client. At times there are even ironic situations in worker conpensation. As an example, a self employed worker may have to file a worker compensation claim against him or her self through the insurance carrier for benefits. The person may even experience difficulty collecting.

The nature of the disability causes different issues which the rehabilitation counselor must address in a counseling context. In worker compensation the counselor deals with the client and the nature of his/her injury. Feelings related to the employer and the nature of the job are often the focus of counseling. In public rehabilitation programs there is not always a specific incident or situation which led to the disability. With developmental disabilities the client has had the disability since birth or during the developmental years.

Disability in proprietary rehabilitation can cause tremendous dysfunction and dislocation. This also becomes an area for the rehabilitation counselor to focus on in counseling for a return to work. The injured and disabled worker may be marginally literate. At the time of the disability that person may be earning a salary that he/she would be unable to earn without the physical ability to perform the work. Thus, issues of self-esteem come into play. The injured worker may be reluctant to enter a job that pays at the minimum wage. He/she may feel (and rightly so) that this is not enough money to support a family. School may not be appropriate because the individual may not be prepared for the demands and expectations of an academic program.

Rehabilitation counselors in proprietary programs face a number of ethical issues. One issue that comes up on a frequent basis is who is the client? Is it the person with the disability who is being served or the person paying the fee. Counselors are taught to advocate for their clients. However, the extent of advocacy maybe limited if the counselor is told that the case will be assigned elsewhere if the requested service is not provided. The insurance adjustor is not another rehabilitation professional. Many times the rehabilitation counselor expects that individual to have a human service orientation. The reality is that the adjustor has been trained in insurance, not counseling.

As is evident the source of funding in public and proprietary programs differs. The public program is financed by tax dollars whereas proprietary programs are financed by money from worker compensation, long term disability, and other forms of insurance. However, public and proprietary rehabilitation counselors are encouraged to identify third party sources of funding to pay for services. In some instances this can include insurance or public rehabilitation programs.

The public program is an eligibility program. All persons are entitled to an evaluation of rehabilitation potential and possibly services. In contrast, proprietary rehabilitation programs are entitlement programs. A person has to have a work related injury or other injury covered by the insurance policy in order to receive services. This serves to limit the persons who can be served by insurance rehabilitation programs.

Insurance rehabilitation typically has two types of professional providers. Although different, their roles may at times overlap. Rehabilitation nurses are used as an extension of the insurance company for medical management and to monitor the persons recovery from the injury or disability. Rehabilitation counselors have a role similar to that which they have in public rehabilitation programs. That is to provide vocational rehabilitation services. Thus, the rehabilita-

tion counselor takes the medical and physical functioning of the client and relates this information to educational and vocational data and then recommends a rehabilitation program for the client within the guidelines of the worker compensation legislation.

An emphasis is placed in proprietary rehabilitation in placing the disabled or injured worker back with the same company and a similar or related job. This may not be possible in the public rehabilitation program if there is not an employer for the person to return. The rehabilitation counselor works closely with the employer in the return to work process in proprietary rehabilitation programs. There is usually a reliance on work hardening and conditioning programs to help the injured worker regain the stamina and physical conditioning necessary for a return to the job. The counselor relies on an assessment of residual and transferable vocational and work skills. Job placement is emphasized in both public and proprietary programs.

The public rehabilitation program is a national program. Although there are some variations in different parts of the country to accommodate differences in client populations and geographic needs, the program is essentially similar in all states. By contrast, worker compensation, long term disability, and other insurance rehabilitation programs differ by state and even within states. As previously indicated, worker compensation programs are supported by legislation in individual states. In addition, with only a handful of exceptions, the worker compensation program within a state will differ depending on the interpretation of the worker compensation carriers in the state. Consequently, each worker compensation carrier may have a different perspective on the worker compensation legislation in the state. It is difficult for states to monitor these differences because of the large number of cases and the relatively small worker compensation staffs maintained by states. Also, frequent changes in legislation make enforcement difficult. With long term disability and other forms of insurance the nature of the particular policy dictates the services offered.

The Americans With Disabilities Act (ADA) may have a positive impact on the return to work of persons with worker compensation injuries. By specifying the essential functions of a job the injured worker can determine whether he/she is qualified to perform a particular job. This will be beneficial for workers who have physical work restrictions. Employers may view the ADA as an avenue to employ the injured worker without the fear of the person being reinjured if he/she is given a task beyond his/her physical capabilities.

Future Developments in Proprietary Rehabilitation

A common denominator of all rehabilitation programs is the fact that they have some kind of medical coverage attached to the services provided. In public rehabilitation that medical provision can extend to all areas in which the individual may need assistance with in order to enter the workplace. In proprietary rehabilitation the coverage relates to the specific problem for which the insurance is to cover.

How both public and proprietary rehabilitation programs function may change in the future if national health insurance provides coverage for conditions otherwise covered by the medical benefits of public and proprietary rehabilitation. At least two directions are possible, one of which will have profound effects on rehabilitation service in all areas. One direction would be a continuation of the present procedures of medical coverage which are dictated by the first dollar concept. For example, in a worker compensation situation if a medical service is provided by national health insurance there may be an attempt made to recover the cost of the service from the worker compensation carrier. A public rehabilitation counselor may attempt to recover monies spent on medical services if the individual is a long term disability client. This is the familiar concept of utilizing similar benefits.

The more dramatic approach would be a second option. In this option all medical coverage from all sources would be folded into the national health insurance umbrella. Thus, medical benefits available through public and all forms of proprietary rehabilitation would be provided through national health insurance. This may even be extended to the medical provisions of social security, public assistance, medicare, and medicaid. The impetus for this would be to have a greater pool of funds available to provide medical coverage. Another advantage would be to place under one "policy" all of a persons medical needs and eliminate costs and duplication of services.

Such a move would have a major impact and a redirection of the dollars allocated for the medical provisions of public and insurance rehabilitation programs. It would minimize the need for rehabilitation programs to determine the nature of the medical services required for clients and consumers. That function would be separate and distinct from the rehabilitation program.

Another outcome would be a blurring of the lines between public and proprietary rehabilitation. With it no longer necessary for the rehabilitation counselor to determine the appropriate rehabilitation medical services for which the individual is entitled, the counselor would be free to concentrate on vocational rehabilitation efforts. An extension of the concept whereby medical benefits are folded under the umbrella of national health insurance would be to change the nature of how rehabilitation counseling services are provided. In public rehabilitation programs the counselor is an employee of the state. For the most part in private rehabilitation the counselor is an independent contractor. A merging of these two positions would place all rehabilitation counselors on a contractual basis as in the usual case with other professions. The certified, qualified, or licensed counselors would then be free to provide service to a client from any rehabilitation area. Some might choose to specialize in public rehabilitation. Others might select to specialize in proprietary rehabilitation. Still others might serve all clients.

This would be a radical approach to rehabilitation counseling service provision. However, it may be a logical extension and evolution to the role of the rehabilitation coun-

selor if the medical benefits for all rehabilitation programs are placed under national health insurance. Even if counselors do not become independent contractors in all areas of rehabilitation, changes brought about by national health insurance may have profound effects on how rehabilitation services are provided.

Implementation of Curriculum Components Related to Business and Industry

The second part of this paper will focus on rehabilitation counselor education curriculum issues related to worker compensation rehabilitation.

Several suggestions for the inclusion of worker compensation information in the curriculum will be provided. Hershenson (1988) noted that rehabilitation counselor education has shifted its curriculum and focus to conform to changes in federal policy as a means of gaining federal training funds. He states that these changes have jeopardized the identity and status of rehabilitation counseling as an independent profession.

Habeck and Ellien (1988) suggested that a variety of trends have contributed to the development of disability management programs in industry. In a review of the task force recommendations for rehabilitation counselor education made by the National Council on Rehabilitation Education and the National Association of Rehabilitation Professionals in Private Practice, McMahon and Matkin (1983) noted substantial overlap and agreement on key issues. These include philosophy, placement, medical and psychosocial aspects, and vocational and personal adjustment training.

Rehabilitation Counselor Education Curriculum Issues

Hershenson (1988) noted curriculum development in rehabilitation counselor training programs has been shaped by expectations for practice in public programs. This has been a function of training monies being made available by the federal government to university rehabilitation education programs. He questions whether this places in jeopardy the independence of the rehabilitation counseling profession. However, as McMahon and Matkin (1983) note these is much overlap in the training needs for counselors who obtain employment in public and proprietary rehabilitation programs. Although the clients may have different disabilities, the basic concepts, approaches, theories, and methodologies are similar. The basic goal, the return to work and economic self-sufficiency of persons with disabilities is shared by both programs.

Curriculum areas such as medical and psychological aspects of disability, vocational assessment, case management, job development and placement, counseling skills, and independent living are required for practice in all aspects of rehabilitation counseling. Where there are differences these can be accounted for by different disability groups being served and different strategies bring practiced. The underlying knowledge and skill competencies remain the same wherever the rehabilitation counselor practices.

Rehabilitation Counselor Education Practice Issues

The rehabilitation counselor does not need to make an either or choice: Either you work for a public program or you work for a proprietary program. In fact in some states public and proprietary programs work cooperatively. In a number of instances a special unit has been designated to work exclusively with worker compensation clients. In other states each program uses the other as a similar benefit resource. In other examples, the state worker compensation program recommends that injured workers be referred to the public program for rehabilitation service. The relationship between the public and the proprietary program does not need to be adversarial.

Implications for Training of Rehabilitation Counselors

The literature reflects the finding that high levels of education correlate with skill attainment and professional competence. There is commonality in the training requirements for rehabilitation counselors employed in public and proprietary rehabilitation programs. Thus, it does not appear that an entirely new or even a distinct curriculum needs to be developed for the training of rehabilitation counselors to work in proprietary rehabilitation practice. Many rehabilitation education programs have curriculum component"s which relate to proprietary rehabilitation. These include discussions of worker compensation, disability management, occupational medicine, and disability areas which incorporate head injury, drug and alcohol, and orthopedic impairments.

At the present time many graduates of rehabilitation education programs select to enter proprietary rehabilitation practice. In other instances the career pattern of rehabilitation professionals reflects job change from and to public and proprietary practice. This implies that the basic training received by rehabilitation counselors in masters level training programs is adequate and appropriate for practice in a wide range of professional setting and contexts.

Recommendations for Rehabilitation Counselor Training

The viability of a discipline depends, in part, on the professional training of practitioners and the commitment of field personnel to employ skilled professionals. Public rehabilitation programs which are federally funded are able to basically speak with one voice because of the relatively centralized nature of the source of funding for the majority of public programs. By contrast, proprietary programs are governed by legislation in each state and by the independent nature of service providers. Thus, it would appear to be more difficult for proprietary programs to articulate training needs and to provide incentives to students for training and employers for hiring graduates.

Several approaches are possible to enhance the training of rehabilitation counselors for service in proprietary programs. First, the competencies needed by counselors who enter this area of practice can be further refined. This can help rehabilitation counselor education programs determine the extent to which they train counselors for proprietary service. Second, scholarships for training and paid internships can be offered. Third, a national registry of employment opening and positions can be developed and maintained. Fourth, chapters of professional organizations at the local level can communicate with rehabilitation education programs in their geographic region to discuss training needs. These and other steps can enhance communication and facilitate the placement of rehabilitation education graduates in proprietary programs.

The training of rehabilitation counselors for public and proprietary programs does not have to be a mutually exclusive activity. Much similarity and overlap already exists between these two programs. It is the desire of rehabilitation education programs to maintain their independence and therefore accommodate the training needs of all constituents. This can be facilitated by communication and a sharing of ideas and information.

Implementing a Business-Industry Emphasis in the Curriculum

The inclusion of material in the rehabilitation counselor education (RCE) pre-service curriculum on business and industry has received increased attention in recent years. Both the National Council on Rehabilitation Education (NCRE) and the National Association of Rehabilitation Professionals in the Private Sector (NARPPS) established task forces to explore the training needs for rehabilitation professionals working in proprietary rehabilitation. The Rehabilitation Services Administration (RSA) has expected RCE grant applicants to demonstrate how their programs incorporate training in business and industry, workers' compensation and job placement within the curriculum. In fact, RSA has encouraged programs to place students in business settings for their practicum.

As previously described, services offered in the public program have as their goal the maximization of the client's potential. In the proprietary sector the goal is the return of the injured worker to employment at a level commensurate with the pre-disability level of functioning (Matkin, 1982). McMahon and Matkin (1983) indicate that the most persistent and strongest suggestion in the NCRE and NARPPS reports concerns an increased emphasis on job placement skills.

McMahon (1979) states that in addition to the traditional curriculum, students interested in proprietary rehabilitation should take elective courses covering labor market trends and job analysis, insurance contracts and practices, workers' compensation legislation, and the management of ethical conflicts. Sales and Bissey, (1979) recommended that the following areas of knowledge needed to be added to the RCE curriculum: (a) workers' compensation, (b) basic concepts of insurance, (c) the legal and free enterprise systems, and (d) legal and medical case management.

Lynch and Martin (1982) reported the results of a survey of NARPPS members in which respondents were asked to identify skill and knowledge areas considered important for effective provision of rehabilitation services in the proprietary sector. The areas rated as most important tended to be of a tangible skill-based nature and geared more toward assessment and outcome activities such as placing a client into employment as opposed to process activities such as coordination of services.

Developing Business and Industry Curriculum Components

With regard to addressing the potential work roles, employment sites, and expected competencies of graduates, rehabilitation counselor education programs are confronted with the dilemma as to whether (a) the current curriculum meets this need, (b) the curriculum basically meets this need, with minor modifications to the content and structure of some courses, or (c) an entirely new course is needed to address these issues. In the Graduate Program in Rehabilitation Counseling at the University of Kentucky the following activities have been undertaken to determine the need for coursework related to business and industry.

After obtaining information from practitioners and professionals a determination was made of the core knowledge and skill competencies required to effectively function as a rehabilitation counselor in business and industry. The faculty then reviewed the current course offerings to determine (a) where there was overlap in course material, (b) where there was appropriate materials, but the emphasis might need to be changed for business and industry, and (c) where there was no material offered in this area.

The results of this process indicated that for the most part the curriculum already contained material for business and industry practice. The major difference was the emphasis given in class lectures and discussions. Not included, but needed in the curriculum was information about workers' compensation legislation and philosophy, liability and auto insurance, personal injury, proprietary rehabilitation systems, working with other professionals, and providing expert testimony. Course content related to medical aspects of disability, vocational evaluation, consultation with employers, and job placement was presently included in the curriculum, but would need to he modified to accommodate practice issues in business and industry rehabilitation.

Upon further review and reflection it was determined that rather than modify and add new material to existing courses, a new course covering business and industry related topics should be developed. Such an approach would have the added benefit of including a review of reports by treating physicians, transcripts of depositions, afid issues related to actual rehabilitation practice as part of a class that would be directed primarily to these topics. This course would be the primary "home" for curriculum components related to business and industry.

Implementing a Course on Business and Industry Rehabilitation

The course on business and industry rehabilitation was designed to incorporate issues in both public and proprietary rehabilitation. The course includes the following topical areas (a) philosophy of business and industry rehabilitation, (b) review of different systems in proprietary rehabilitation, (c) overview of disabilities frequently encountered (d) assessment, planning, and process issues, (e) residual and transferrable skill assessment as well as the use of computerized job matching programs, (f) consultation with employers and job placement, (g) working with claimants, insurance companies, attorneys, physicians, and nurses, (h) vocational expert testimony and (i) ethical and legal issues.

Summary

The parallel development of public and proprietary rehabilitation programs has led to the utilization of rehabilitation counselors in both sectors.

Traditionally rehabilitation education programs have been supported by the federal government. There has been some concern that rehabilitation counselors trained in these programs have not worked in the public program, but have been recruited by proprietary rehabilitation programs. It is evident that both public and proprietary rehabilitation utilize similar techniques and approaches. There is overlap between the expectations of public and proprietary rehabilitation practice. Changes resulting from national health insurance may have profound effects on how rehabilitation services are provided in all areas of professional practice.

References

Conley, R., and Noble, J., Jr. (1978). Worker's compensation reform: Challenge for the 80's. *American Rehabilitation, 3*(3), 19-28.

Haback, R.V., and Ellien, V. (1986). Implications of worksite practice for rehabilitation counselor education and training. *Journal of Applied Rehabilitation Counseling, 17*(3), 49-54.

Hershenson, D.R. (1988). Along for the ride: The evolution of rehabilitation counselor education. *Rehabilitation Counseling Bulletin, 31*(3), 204-217.

Lynch, R.K., Lynch, R.T., and Beck, R. (1992) Rehabilitation Counseling in the Private Sector. In R.M. Parker and E.M. Szymanski (Eds.), *Rehabilitation Counseling: Basics and Beyond* (pp. 73-101). Austin, Texas: Pro-Ed.

Lynch, R.K., and Martin, T. (1982). Rehabilitation counseling in the private sector; A training needs survey. *Journal of Rehabilitation 48*(3), ,51-53; 73.

Matkin, R. (1980). Rehabilitation counseling in private practice: Perspectives for education and preparation. *Journal of Rehabilitation, 46*(2), 60-62.

Matkin, R.E. (1982). *Rehabilitation education curricula: Preparing counselors to enter the private for-profit sector.* Report of the Training and Research Committee, National Association of Rehabilitation Professionals in the Private Sector.

McMahon, B.T. (1979). Private sector rehabilitation: Benefits, dangers, and implications for education. *Journal of Rehabilitation, 45*(3), 56-58.

McMahon, B.T. and Matkin, R. (1983). Preservice graduate education for private sector rehabilitation counselors. *Rehabilitation Counseling Bulletin, 27*(1), 54-60.

Sales, A. and Bissey, L. (1979). Placement in rehabilitation education: Curriculum considerations. Monograph, University of Arizona Press.

Sink, J., and Field, T. (1981), Vocational Assessment Planning and Jobs. Athens, GA; VSB, Inc.

Weed, R.O. and Field, T.F. (1986). The differences and similarities between public and private sector vocational rehabilitation: A literature review. *Journal of Applied Rehabilitation Counseling, 17*(2), 11-16.

White, L. (1983). *Human Debris: The injured worker in America.* New York: Seaview/Putnam.

Dr. Crystal discusses the similarities and differences in rehabilitation education needs for the rehabilitation counselor practicing in the private sector versus the public sector. He stresses the need for certain fundamental training on basic knowledge needed by counselors in both settings, and he discusses some additional training that would be of benefit specifically for rehabilitation in the private sector.

I agree with Dr. Crystal's underlying premise that rehabilitation counseling dealing in either a public or private setting utilizes the same basic skills and approaches. However, as Dr. Crystal acknowledges, there is much greater emphasis on prompt placement as a successful outcome for rehabilitation in the private sector.

Because of this, the rehabilitation counselor who aspires to work in the private sector in the future needs to be well-prepared to deal with current job placement issues. As we look at rehabilitation education curriculum for the year 2000 and beyond, the following areas are ones which may undergo rapid change or advancement and need to be incorporated fully into the curriculum:

1. Labor market information - changing occupational patterns and job requirements.
2. Work place technology/assistive technology advancements, as they relate to job accommodation.
3. Ergonomics.
4. Placement techniques and issues.

While these topics are extremely important to the rehabilitation counselor practicing in the private sector, it appears public sector counselors would benefit from more training in these areas as well. Incorporating these may provide an overall strengthening of rehabilitation counselor education.

– Catherine C. Bennett

Dr. Crystal's paper, which emphasizes the development of rehabilitation with particular attention to worker's compensation in the various states, reminds me that our field is not our exclusive domain but rather is subject to control and influence by many factors to which we can of necessity only react. For example, we don't have great influence over the laws that sometimes mandate our services, but rather 'react' or deliver our services under their provisions.

The degree to which rehabilitation is going to be perceived as a viable and useful adjunct to the other helping professions, however, is more under our control than not, and as a profession the time has come for us to plan our future and work for its achievement. We have models of successful achievement of similar activities that we can look to for our edification, such as the efforts of psychology as a profession, which has planned and lobbied for its present position in the provision of health care and similar services in the United States of today.

Any such activity must start from a solid foundation of practice, which Dr. Crystal alludes to in his paper. For example, we expect our students and practitioners to be solidly grounded in the basics of evaluating and understanding human behavior in the context of many different settings. It is still our obligation to use this and many other areas of knowledge in the unique way that is compatible for our profession's sound practice, continued growth, and for its recognition by other professionals as a useful adjunct to their joint efforts in the overall rehabilitation of persons with disabilities.

– Phillip Bussey

Dr. Crystal provides an excellent discussion of the historical development of private sector rehabilitation with business and industry. The discussion includes an overview of both similarities and dissimilarities between the public sector and private sector rehabilitation movement, especially as it relates to issues in the field of workers compensation.

Central to Dr. Crystal's discussion, however, is the issue of "Who is the client"? Dr. Crystal identifies, "the basic goal is the return to work and economic self-sufficiency of persons with disabilities as being shared by both programs." In my opinion this is not necessarily an assumption that is always correct. Historically, the client has been the person with a disability or handicap as addressed by the state and federal laws for the last fifty years in vocational rehabilitation. I would agree that private sector rehab has also identified the injured worker as the primary client in the vocational rehabilitation process in the private sector. I do not think this is the case. Quite frankly, the client in private sector rehab is really best represented by attention given to all players or parties in the process called "return to work" of that injured worker. For instance, the insurance company that hires the rehabilitation client plays a very substantial role in the process which in turn is governed by state laws and regulation for workers compensation delivery programs. Attorneys who represent either insurance or the injured worker feel that they have a very significant role in the process as does the employer who is being assaulted with spiraling compensation insurance premiums. Finally, the injured worker him or herself is obviously a major player in the process although sometimes it may seem to this person that the overall goal is to save money for both the insurance carrier and the employer and not necessarily the total rehabilitation of the worker.

With respect to the academic or technical preparation of the rehab consultant either in the public or private sectors, Dr. Crystal has argued that the knowledge and skill competencies remain the same for both groups. Dr. Crystal argues further that, "it does not appear that an entirely new or distinct curriculum

needs to be developed for the training of rehabilitation counselors to work prior to rehabilitation practice:

The accompanying paper by Dr. Gilbride clearly identifies a major thorn in the side of private sector rehabilitation administrators and practitioners. Dr. Gilbride correctly observes, "Students receiving a scholarship support from RSA to attend a training program must work in a state agency two years for every year of tuition support received". And further, "financial dependence on RSA results in training that is narrowly focused on public rehabilitation:" I tend to be more in agreement with Dr. Gilbride who questions the RSA universities training programs' capacity to train students to enter proprietary rehabilitation. While a new area of curriculum does not necessarily need to be developed, I am in concurrence with Dr. Crystal's effort at the University of Kentucky to develop specialized courses and areas of expertise that more fully address the needs of rehabilitation consultants entering the private sector area.

– Tim Field

Historical origins surrounding the development of workers' compensation programs in the United States are presented well by Dr. Crystal. Social issues and legal principals are included in the discussion which lead up to the inclusion of rehabilitation in workers' compensation legislation and the rise of proprietary rehabilitation programs in the workers' compensation system. Similarities and differences between proprietary and public rehabilitation programs are discussed in terms of goals, clientele, counseling context, ethical issues, funding sources, eligibility vs. entitlement programs, and national vs. state programs. Although the types of professional providers in insurance (proprietary) rehabilitation are also discussed, exception is taken with the identification of only two such providers: rehabilitation nurses and rehabilitation counselors. Among the many other types of professional providers are: vocational evaluators, occupational therapists, physical therapists, employee assistance professionals and medical doctors.

Rehabilitation counselor education curriculum issues related to workers' compensation rehabilitation are also presented. There appears to be some contradiction and confusion in the discussion of training needs for counselors who pursue employment in the private sector vs. the public sector. It is true that there are some commonalities between rehabilitation counselors in by Crystal

both sectors such as the goal of rehabilitation and the knowledge of such content areas as vocational assessment, case management, counseling skills, medical and psychological aspects of disability, and job development and placement. However, the approaches, methodologies and theories are oftentimes dissimilar and may reflect more than a difference in disabilities. It may be a reflection of legislative mandates, employment settings, and business theory and practice, to name a few. This translates into a difference of some knowledge and skill competencies for the rehabilitation counselor employed in a proprietary program as opposed to the public program.

While the content of the training curriculum for rehabilitation counselors in public and proprietary programs does not have to be a mutually exclusive activity, as the author points out, additional applications (e.g., life care planning, expert testimony, transferable skill analysis) and theoretical frameworks (e.g., business, insurance, law) are necessary to provide adequate preparation for employment in the private sector. Rehabilitation educators must be willing to expand their frame of reference to and knowledge base of rehabilitation practice beyond the public system.

The phrase "business and industry rehabilitation" is mentioned several times in the text of this manuscript, particularly in the latter half, and appears to be used synonymously with "workers' compensation rehabilitation. " It is important to note that rehabilitation in business and industry may involve the workers' compensation system but it also includes other insurance systems, ADA consultation, life care planning and employee assistance programs.

– Juliet H. Fried

This paper raises a number of interesting issues that have significant implications for understanding the role of proprietary services in the field of vocational rehabilitation. A fundamental difference exists between the goals of public and proprietary rehabilitation. Crystal points out that the goal of the proprietary rehabilitation system is returning the injured worker to their prior or related level of vocational, physical and/or mental functioning.

In contrast, public rehabilitation attempts to assist the client "to attain his/her full potential". This difference in the definition of outcome accounts for many of the process contrasts between the two systems.

Proprietary rehabilitation tends to emphasize early and fast return to work, utilization of transferable skills, and placement services. Public rehabilitation tends to take longer and may include more schooling, "work adjustment," counseling, and other community resource utilization. The field of rehabilitation clearly needs more process and outcome research to identify the effectiveness of the services and techniques utilized by both systems.

A second important issue raised by Crystal is the role of pain in the rehabilitation process with injured workers. Training programs and service providers need a clearer understanding of the profound impact that pain has on a consumer, and how it affects rehabilitation planning and return to work.

– Dennis Gilbride

In an excellent overview of rehabilitation and the role of rehabilitation counselors in public and private settings, the author addresses the similarities and differences, as well as the

implications for training, for public and private practice.

Two specific areas that I believe warrant further attention and development, either by educational institutions or professional associations, are the concepts of a national registry and paid internships. Often times, rehabilitation counselors that are not in the "private arena", or who do not have connections into same, may wish to explore opportunities in the private sector but may not have resources adequate for a thorough exploration. A comprehensive registry of private entities nationwide, would enable persons to explore not only within their own state, but also to see what's happening in other areas of the country, where they might not have contacts or knowledge of opportunities.

The concept of paid internships is one that has been in existence for some time, but I have a feeling has been underutilized in the insurance rehabilitation arena. This is a great way for students to experience application of their newly-learned skills in an exciting, challenging setting, and for the private rehabilitation provider to work with someone who is fresh to the field, typically motivated, enthused, and full of new ideas and strategies. The employer also has a unique opportunity to "try-out" a professional for a time-limited period, and if a good match is made, have a master's level counselor ready to hit the ground running at the end of the internship. Additionally, that intern would be adding productivity to the setting, during their learning period, which is a clear, "bottom line" benefit to the rehabilitation company.

Finally, I want to comment on one distinction cited by the author relative to insurance rehabilitation having two types of professional providers: rehabilitation nurses and rehabilitation counselors. While I do know that some statutes across the country mandate that certain "types" of rehabilitation services must be provided by specific professionals, my experience with CRR (a private rehab company) in New Jersey is that a highly skilled, well-trained rehabilitation counselor can be an effective medical case manager. Conversely, a highly-skilled, well-trained nurse can be extremely successful in the vocational arena. A properly trained rehabilitation counselor has the basic medical knowledge upon completion of their training, and have the ability to seek out information on medical issues with which they are unfamiliar. Likewise, the nurse with strong medical knowledge and the ability to apply said knowledge in a private rehabilitation setting, as well as the ability to interact with a wide range of individuals (employers included) will have no problem in learning the vocational issues relative to return to work.

– Patricia Nunez

Besides providing a historical perspective of workers' compensation system in this country, Dr. Crystal touches upon two key issues: The Americans with Disabilities Act (ADA) and its possible benefits to industrially injured workers; and rehabilitation counselor education.

There is no doubt that ADA will have a "positive impact on the return to work of persons with worker compensation injuries". The concept of essential functions will define clearly the requirements of the job thus allowing for true job match and therefore addresses Dr. Crystal's comment on "employer's fear of the person being re-injured". ADA, as a matter of fact, cannot arrive at the most appropriate time to tackle the workers' compensation turmoil. The application of essential functions and reasonable accommodations will assist employers to retain and re-hire their own injured employees thus reducing the exposure of higher premium due to experience rating. In the long run, it will create a much safer environment at the work place further reducing the frequency of injuries. With lesser overhead cost, i.e. workers' compensation insurance, the employer can become more competitive in the market, can treat the employees better in terms of wage increases and employee benefits, and can better invest in their plant equipment and/or safety equipment, etc. Needless to say, the insurance industry will benefit. It is a win-win-win situation for all.

While it is true that the rehabilitation professionals in both the public and private sector employ the same underlying skills and knowledge, practicing rehabilitation within legal systems does require different approaches and methodologies. It is therefore vital for rehabilitation counselor education programs to include courses or minimally " a course on Business and Industry Rehabilitation" as outlined by Dr. Crystal. This will provide an excellent introduction to all future rehabilitation counselors. For the students who are going into the public sector, this will give them some understanding of the disability benefit systems, industrial rehabilitation and forensic rehabilitation. For the ones entering the private sector, this will give them an orientation to the field of their choice. Ultimately, this will foster a better public/private partnership and relationship.

– John W. Lui

In this paper, Ralph Crystal documents the development of worker's compensation programs with our country's economic shift from an agrarian to an industrial economy. Community social support was required to replace the declining support once available from predominately rural extended families. Reflecting a tradition of state's rights, each state responded with worker's compensation programs designated to address their perceived unique needs. Although the federal government also developed a worker's compensation program for federal employees, comparisons are too frequently made between proprietary rehabilitation and the traditional state/federal rehabilitation system rather than the more analogous federal worker's compensation program.

Private Sector rehabilitation developed in response to the observation

that the cost of services could be reduced while restoring an individual to their pre-injury or similar level of occupational attainment. These cost savings were primarily a result of the private practitioners goal to restore an individual rather than maximize an individual's employment potential.

Public vocational rehabilitation has also traditionally blended human with economic values. This socioeconomic blend is reflected by rehabilitation advocates early use of the concept with policymakers that there has been a favorable return for very tax dollar spent on rehabilitation services.

Acknowledging the existence of differences associated with funding sources, Crystal correctly concludes there are more similarities than differences between the potential sectors of employment for rehabilitation practitioners. At one point, Dr. Crystal even notes that employment in public or proprietary rehabilitation is no longer an "either or choice" for practitioners.

Emphasizing similarities encountered by rehabilitation practitioners, while identifying differences requiring redress through curriculum adjustments, has profound implications for the training of rehabilitation professionals. First, it implies that sufficient identifiable techniques, approaches and a fundamental knowledge base exist to warrant professional training of rehabilitation counselors. Secondly, it constructively addresses the need for adjustments in curriculum to prepare individuals to enter a more diverse labor market without the incessant need for specialization which has divided rehabilitation professionals in the recent past. Finally, it emphasizes the need for the profession to define itself rather than allow revenue sources to define the profession.

– Stephen A. Zanskas

Chapter Two

Educating Practitioners for Work in the Private Sector

Dennis David Gilbride

Vocational rehabilitation services in both not-for-profit and for-profit private rehabilitation have changed dramatically over the past ten to fifteen years (Cohen & Pelavin 1992; Gilbride, Connolly & Stensrud, 1990; Menz, & Bordieri 1986). While the focus in private rehabilitation has traditionally been on employability and placement of people with disabilities, non-profit and for-profit practitioners are increasingly approaching these goals differently. Many non-profit agencies are moving toward a supported employment model, (Bellamy, Rhodes, Mank, & Albin, 1988; Buckley, Albin, & Mank, 1988; Wehman, & Moon, 1988), while for-profit rehabilitation is moving into consulting and other disability management services (Lynch, Lynch, & Beck, 1992).

This divergence in job tasks and necessary skills raises significant and fundamental questions concerning the type of education required by personnel entering private rehabilitation settings. These questions include delineation of appropriate training content and outcome competencies, and the most effective manner of providing training (Lynch & Martin 1982; Matkin, 1987; Matkin & Riggar, 1986; Sales, 1979).

The purpose of this paper is to explore these training-related issues. The first section will address the context in which private for-profit rehabilitation professionals work, and the implications these factors have for training. The second section will address forensic and ethical issues in rehabilitation. The third section will briefly discuss the training needs of non-profit rehabilitation professionals and provide an example of a market driven approach to curriculum development. The final section of the paper will present some tentative conclusions and issues requiring further exploration.

Dennis David Gilbride Ph.D. CRC, Assist. Prof., Rehabilitation Institute, Drake University, Des Moines, Iowa

Private For-Profit Rehabilitation

Rehabilitation services in the for-profit sector have undergone profound growth and change during the past two decades (Gilbride, Connolly & Stensrud, 1990; Lynch, Lynch, & Beck, 1992; Taylor, Golter, Golter, & Backer, 1985). Counselors are working in a wider range of contexts, with clients having different types of disabilities, and they are employing new strategies and technologies (Lynch, Lynch, & Beck, 1992; Ritter & Leclair, 1990; Williams & Fidanza, 1990). To understand the training needs of professionals in the for-profit sector it is important to understand five aspects of the current environment: 1. Where private-for-profit professionals are likely to work, 2. The importance of being a Certified Rehabilitation Counselor (CRC), 3. The role of accreditation of training programs by the Council on Rehabilitation Education (CORE), 4. Rehabilitation Services Administration (RSA) training grants and payback requirements, 5. Professionals against whom rehabilitation personnel are in competition.

1. *Where are for-profit rehabilitation professionals working?*

The simple answer is everywhere. Using Drake University as an example, alumni of the rehabilitation program work as directors of personnel in business and industry; as ADA consultants to employers; in private practice providing expert testimony; in medical settings as part of transdisciplinary teams; in psychiatric club houses; at insurance companies; in for-profit (insurance) rehabilitation agencies; and as career, mental health and substance abuse counselors. Research indicates that this is not an unusual or atypical list (Lynch, Lynch, & Beck, 1992; Matkin, 1983; Williams & Fidanza, 1990).

The broad range of settings in which for-profit rehabilitation professionals are currently working creates significant challenges for developing appropriate training ap-

proaches. For example, business consulting and personnel development obviously require very different competencies than those necessary for providing job seeking skills to clients with head injuries or substance abuse.

Development of appropriate curricular and training models requires educators and other stakeholders to first identify what is basic and fundamental to vocational rehabilitation. Substantial disagreement exists among leaders and educators in the field of rehabilitation concerning how broadly this basic core should be defined. This is clear from a review of the literature (e.g. Matkin, 1987; Matkin & Riggar, 1986; Parker & Szymanski, 1992; Rubin, Matkin, Askhley, Beardsley, May, Onstott, & Pucket, 1984), and was demonstrated a number of times in the National Training Conference on Rehabilitation Education held during March of 1993, in Washington DC.

For the purpose of this paper the key area of expertise necessary for all rehabilitation professionals will be narrowly defined as the knowledge and skills necessary to negotiate the interface of disability and the world of work. The interplay between disability and work is clear in such rehabilitation services as placement, employer development, work accommodations, disability management and ADA compliance. Because rehabilitation professionals are the primary group within the medical and helping professions who use employment as an outcome measure, they offer the capacity to tie rehabilitative services together across the recovery process.

There are two key implications of this definition of vocational rehabilitation. First, employers are hiring rehabilitation professionals in all the capacities listed above because they perceive the importance of this unique expertise. Second, successful training programs must ensure that their curricula, teaching methods, projects, and fieldwork experiences result in students developing quality skills in this disability/work relationship.

The effectiveness of the training currently provided to private for-profit professionals by existing programs is the subject of some debate. Defenders of current educational approaches point to the success that rehabilitation professionals have in obtaining positions. Those who advocate change cite data indicating the questioning occurring in many states regarding the effectiveness of vocational rehabilitation with workers' compensation clients. While there are many complex financial and political reasons why many state legislators are repealing the mandatory rehabilitation provisions of their workers ' compensation systems, private rehabilitation providers' inadequate documentation of their effectiveness, (along with ethical and conflict of interest questions) is at least partly to blame (Washburn, 1992).

2. *The importance of being a Certified Rehabilitation Counselor (CRC).*

In a review of all the job openings listed in NARPPS Journal and News over the past two years, and all of the for-profit rehabilitation position announcements sent to Drake University, two conclusions become apparent: Employers want applicants with either a master's degree or BSN, and they want people who are certified. The majority of employers require (or at least prefer) applicants to have a CRC, with some employers also accepting Certified Insurance Rehabilitation Specialists (CIRS), and a few recruiting Certified Vocational Evaluators (CVE).

This strong emphasis by for-profit employers on certification has significant implications for education and training. On December 15, 1992, the Bachelor's degree category for CRC eligibility was phased out, along with the category for master's degrees unrelated to rehabilitation. Consequently, beginning this year, only people with master's degrees in rehabilitation counseling or related programs will be eligible to sit for the CRC examination. This tightening of CRC requirements will have a significant impact on the labor pool because over one-third of the applicants for CRC prior to December of 1992 held bachelor's degrees (Commission on Rehabilitation Counselor Certification, 1992).

A master's degree in rehabilitation, with certification, has almost universally become the entry level requirement in for-profit rehabilitation. People planning to enter this labor market will increasingly be forced into attending graduate school at a university or college offering a rehabilitation counseling degree program.

Further, CRC renewal requires 100 hours of continuing education. This requirement has created an entire industry of continuing education providers, which has in turn created an infrastructure by which new ideas, strategies and technologies can be introduced into the field.

3. *The role of accreditation of training programs by the Council on Rehabilitation Education (CORE).*

There are currently 77 master's degree programs accredited by CORE. A number of advantages accrue for students graduating from a CORE accredited program, including their ability to sit for the CRC examination immediately, (whereas other students must wait between 1 to 3 years). CORE has very explicit and extensive guidelines on curriculum, course content, fieldwork requirements and program length. Seven years ago Matkin and Riggar (1986) argued that CORE needed to reevaluate its guidelines to become more sensitive to and relevant for private for-profit rehabilitation. This has not occurred. In a more recent study, Gilbride, Connolly and Stensrud (1990) found that most CORE accredited programs did not have any courses related to the specific application of vocational rehabilitation in the private sector. The content, structure and process outlined by CORE is still focused on, and most appropriate for public rehabilitation.

It is also important to note that CORE currently only accredits master's degree programs in rehabilitation counseling. While CORE is considering certification of other programs they do not presently accredit undergraduate programs, or other rehabilitation master's degree programs such as those in job placement, vocational evaluation, or facilities administration.

With CRC and CORE accreditation of programs becoming more important, much more attention must be paid to CORE standards and their impact on and relevance to preparation of private-for-profit professionals.

4. *Rehabilitation Services Administration (RSA) training grants and payback requirements.*

There are currently 49 master's degree programs in rehabilitation counseling that receive funding from RSA. Of these programs 45 (92%) are CORE accredited representing 58% of all CORE accredited schools. Further, for every one program funded by RSA, two to three programs apply for funding but are denied. This implies that almost all CORE and many non-CORE accredited schools are either receiving or trying to receive grant support from RSA.

In order to receive funding from RSA, a degree program must demonstrate that it's mission matches that of the State/Federal vocational rehabilitation program, and that it has strong linkages with public and non-profit rehabilitation. The mission, goals, objectives, curriculum, course content, and fieldwork requirements of the program must focus on public rehabilitation. Further, students receiving scholarship support from RSA to attend a training program must work in a state agency (or a non-profit agency providing services to state agency clients) two years for every year of tuition support received. Usually this "payback" work must take place within the six year period following graduation.

There are two opposing impacts of RSA funding of rehabilitation training programs on for-profit rehabilitation. First, this funding has resulted in a large number of high quality, well supported rehabilitation degree programs dispersed throughout the United States. However, financial dependence on RSA results in training that is narrowly focused on public rehabilitation. Consequently, there is the university capacity to train students to enter for-profit rehabilitation, but no incentive for programs to diversify into training designed to meet the needs of the for-profit sector.

5. *Professionals against whom rehabilitation counselors are in competition.*

One reason rehabilitation training programs are dependent on RSA funding is that schools have difficulty recruiting non-scholarship supported students. Many students interested in a career in rehabilitation find it very difficult to reject grant support that often includes both tuition assistance and a monthly stipend. Given the financial and personal rewards of working in the private for-profit sector, it is important to address the reasons why training programs are not overwhelmed by self-pay applicants.

To understand this issue we must first ask who are rehabilitation professionals? Holland (1990) lists vocational rehabilitation counseling as a Social-Enterprising-Conventional (SEC) occupation. Other SEC occupations include elementary school teacher, probation officer, school social worker, and psychiatric aide. If we look just at the first two themes (SE), occupations include detective, hospital administrator, school psychologist, director of special education, and psychiatric social worker. An implication of these lists is the large number of well known professional level jobs that people with these vocational interests and personality type might pursue.

Private for-profit rehabilitation is a relatively new and unknown profession. Most of the occupations listed above are jobs about which the average college age student has ample information. Students know what psychology is, but vocational rehabilitation often makes students think of prisons, vocational training schools, or worse yet—nothing. The National Council on Rehabilitation Education (NCRE) has begun to address the need to increase awareness of the profession to improve recruitment (Pacinelli & Stude, 1991).

Competition for jobs is another critical factor. Rehabilitation professionals are often competing for jobs with social workers or mental health, substance abuse, employee assistance, and family counselors. In order to be selected, rehabilitation professionals must demonstrate they have expertise in the disability/work relationship, and that this skill is necessary for a specific job.

There are three implications of these competitive issues for rehabilitation education. First, training programs must focus recruitment on high school and undergraduate students who have personalities that match the work environment of rehabilitation and provide information to prospective students on all the options a rehabilitation degree offers. Second, rehabilitation graduates need to be trained to clearly market their expertise and to represent how they can do the work employers require. Third, rehabilitation educators (among others) must continuously demonstrate to the medical and helping services the importance of looking at vocational issues, and assist business and industry to appreciate the positive outcomes that derive from understanding and accommodating people with disabilities.

Forensic Issues in Private Rehabilitation

Insurance rehabilitation has traditionally had a great deal of interaction with the workers' compensation legal system (Matkin, 1985). This experience has helped prepare professionals to understand the type of documentation required, and the scrutiny that occurs in forensic settings. Recently, rehabilitation professionals have begun to expand their practices into life care planning and expert vocational testimony (Blackwell, 1991; Deutsch & Sawyer, 1986; Vogenthaler & Tierney, 1990; Weed & Field, 1990; Weed & Riddick, 1992).

Life care plans delineate all the services and products that persons with catastrophic injuries or illnesses may need over their life time (Weed & Field, 1990). Because life care plans are often used as the basis of a settlement with an insurance company it is vital that the information be accurate and comprehensive. Because of the underlying requirement for complex analysis of economic trends, life care planning is often done in conjunction with an economist (Weed & Riddick, 1992). For example, a life care plan may need to include the potential cost of a wheelchair and routine physician visit in the year 2013. Life care plans are often conducted by rehabilitation nurses however, rehabilitation

counselors with extensive experience and training in the medical needs and impact of specific disabilities (i.e. head injury) are increasingly becoming involved in this work.

Expert vocational testimony is generally concerned with the impact of a disability on labor market access and earnings capacity (Blackwell, 1991; Vogenthaler & Tierney, 1990; Weed & Field, 1990). While some vocational testimony does not include a disability (as in the case of marriage termination), the disability/work relationship is usually central to this process. As with life care planning, economic analysis is pivotal to expert testimony. Understanding the level of economic loss resulting from a specific injury, accident or disease, requires an in-depth understanding of worker characteristics, disability, and labor markets, along with a decision making model that can be clearly defended.

Although rehabilitation professionals are utilized as life care planning and forensic testimony experts, traditional rehabilitation counseling training is generally not enough to qualify a practitioner for this work (Deutsch, 1985; Blackwell, 1991). Most expert witnesses obtain post-masters' experience and training in techniques such as transferable skills analysis, wage loss calculation, labor market analysis, economic projections, medical technologies, and legal processes.

Most training in forensic rehabilitation has occurred in specialty workshops and at professional conferences sponsored by private rehabilitation organizations such as the National Association of Rehabilitation Professionals in the Private Sector (NARPPS). For a number of years forensic rehabilitation has been one of the specific training tracks at NARPPS national conferences. Rehabilitation professionals are also taking graduate courses outside of rehabilitation in departments of economics, business, law and psychology.

Ethical Issues in Private Rehabilitation

The need for rehabilitation professionals to be trained in ethical decision making began to receive attention in the mid 1980's (Rubin, 1993). In 1987 the National Institute on Disability and Rehabilitation Research (NIDRR) funded a grant to develop and evaluate an ethics training package. This grant resulted in a number of studies exploring the types of ethical dilemmas rehabilitation professionals encounter, and training material for ethics education. A subsequent NIDRR grant further supported development of ethics curricula.

A central focus of ethics training is assisting professionals in the development of analytical ethical decision making skills (Fischer, Rollins, Rubin & McGinn, 1993). Most ethics training is based on the *Code of Professional Ethics for Rehabilitation Counselors* that has been adopted by CRC, the American Rehabilitation Counseling Association, the National Rehabilitation Counseling Association and the National Council on Rehabilitation Education.

There are three major problems with the application of ethics research and training to the private sector. First, most non-profit rehabilitation professionals are not certified rehabilitation counselors, and are not members of one of the national counseling associations. Second, NARPPS has a different code of ethics for its membership. Third, ethics training has only been field tested in state/federal rehabilitation agencies (Fischer, Rollins, Rubin & McGinn, 1993). Consequently, most ethics research and materials are focused on the ethical dilemmas encountered by public rather than private rehabilitation practitioners.

While the public rehabilitation focus of ethics research and training is only of limited concern for non-profit professionals, serious differences exist between appropriate professional behaviors in public and for-profit settings. The significant ethical differences between public and for-profit rehabilitation have been noted for a number of years (Kaiser & Brown, 1988; Nadolsky, 1986), and they include the "Who is the client?" question, and the "cost containment" focus of rehabilitation services in some situations.

Both public and non-profit rehabilitation professionals clearly view the person with the disability as their central customer, and the needs of consumers as primary. The situation is not as clear in for-profit rehabilitation, and in fact may be the exact opposite. Many for-profit rehabilitation professionals are hired by employers or defense attorneys with the explicit intent of reducing that employer's exposure and containing the cost of a claim.

The NARPPS code of ethics specifically allows for objective expert testimony, and states that "When there is a conflict of interest between the disabled client and the NARPPS member's employing party, the member must clarify the nature and direction of his/her loyalty and responsibilities and keep all parties informed of that commitment" (NARPPS, 1992, p.22). Thus, NARPPS only requires the member to disclose who their primary client is, it does not require, as does the CRC code of ethics, that the needs of the person with a disability always come first.

Consequently, rehabilitation professionals in the for-profit sector find themselves continuously in complex ethical dilemmas. The for-profit sector recognizes this and frequently has workshops or entire training tracks devoted to ethics at its national convention. The problem is that the money to support ethics research and training has only been provided by, and focused on public rehabilitation. Thus, the pre-service training that most rehabilitation professionals received did not adequately prepare practitioners for the complex ethical decisions they would have to make, and in-service ethics training has been available only on a limited basis.

Private Non-Profit Rehabilitation

Community Rehabilitation Programs (or non-profit facilities) are also undergoing significant change. In their study of personnel shortages Cohen and Pelavin (1992) found significant need for trained workers in the areas of supported employment, job development/job placement, vocational evaluation and administration.

Supported employment is the fastest growing area in community rehabilitation agencies (Renzaglia & Everson 1990). Cohen and Pelavin (1992) found that a high school

degree was the educational requirement for 58% of all supported employment positions, and that a specific bachelor's degree was only required for 9% of positions, with no positions requiring a master's degree. Most supported employment training is conducted on-the-job, in short term certificate programs or at community colleges. The educational requirements for the other three high need positions (job developers, vocational evaluators and administrators) were more varied.

A market-driven approach to curriculum development was utilized to determine the specific educational needs and requirements for rehabilitation administration in a community rehabilitation program. Stensrud and Gilbride (1992) conducted a study using a marketing model of curriculum development (Kotler & Bloom 1984; Levitt 1986). Degree requirements and course offerings from thirty-one existing undergraduate rehabilitation programs were collected and collated. The professional literature was reviewed to determine recommended competencies for rehabilitation facility administrators. (The literature review included: Bordieri, Riggar, Crimando & Matkin, 1988; Brabham & Emener, 1988; Menz & Bordieri, 1986.)

These data were summarized and presented to a focus group comprised of five facility administrators, one state agency administrator, and the director of the Iowa Association of Rehabilitation and Residential Facilities. The focus group discussed the training needs of the employees in their agencies and reviewed the summary of the competencies and course offerings provided to them. The focus group made recommendations concerning curriculum and degree type, and composed a draft list of competencies.

This draft list was presented to a subcommittee of the Drake Rehabilitation Institute Advisory Board comprised of rehabilitation consumers. The consumers reviewed the draft list and added additional competencies, degree requirements, and course offerings.

The final step consisted of sending the second revision to the focus group members for comments. After this review a final curriculum with specific competencies was developed. (See Appendix for list of competencies.)

The results of this study suggested, and all the focus group members agreed, that competition with for-profit rehabilitation was a major personnel problem for facilities. Responders indicated that they found it almost impossible to retain employees with master's degrees due to the significantly higher salaries in the for-profit sector. The focus group concluded that bachelor's prepared employees were much more likely to stay at a non-profit agency. Thus, they suggested that training for facility administrators be conducted at an undergraduate level. The focus group also recommended that the training program be more user-friendly to working adult students. This included emphasis on evening and weekend classes, off-campus course work and the use of technologies such as computer bulletin boards to aid student/faculty communication.

Conclusions and Issues For Further Discussion

1. The training needs of public, non-profit and for-profit rehabilitation seem clearly differentiated but rehabilitation counseling programs do not seem to be addressing these differences.

2. The educational requirement of for-profit rehabilitation professionals seems to be at the master's degree level, with postmaster' s specialty areas becoming more common.

3. There is a growing body of information, and specific skills that many private for-profit rehabilitation professionals require such as expert testimony and disability management which training programs are not currently providing.

4. The training needs of non-profit rehabilitation professionals seem to be dominated by short term specialty training and non-degree programs, with only a few positions requiring a Bachelor's or Master's degree.

5. Rehabilitation programs need to expand their recruitment to attract people into the field who would otherwise choose a more traditional career path.

6. Graduate programs in vocational rehabilitation need to develop strategies to broaden their financial base so they can become more responsive to the emerging trends in private rehabilitation. To counterbalance the influence of RSA, the for-profit industry should assist programs in this.

7. Training programs need to become more flexible, relevant and user friendly for students planning to pursue careers in private rehabilitation.

8. Rehabilitation programs need to become more market sensitive and responsive in developing and modifying curriculum and program content. To do this private rehabilitation (particularly for-profit) must work to influence the content and criteria of both CORE and CRC.

In summary, graduate training in rehabilitation counseling often inadequately meets the expanding educational needs of students preparing for careers in the for-profit sector. In order to effectively perform and compete in emerging private sector applications (i.e. expert testimony), students require a great deal of on-the-job, and post service training. While increased education is the trend in for-profit rehabilitation, the non-profit sector increasingly cannot compete for master's prepared students. Thus, two of the primary organizations designed to improve the quality of rehabilitation training and practice--CORE and CRC--are becoming irrelevant for non-profit practitioners. Training that is focused on the competencies required for specific jobs in the non-profit sector (i.e. job coaches) at the certificate, AA or BA level seems to be an emerging trend. While post-service (or in-service) training for non-profit practitioners has traditionally been sensitive and responsive to those agencies' needs, many pre-service training programs have

not. Utilization of a market driven approach to curriculum and degree development is one method by which pre-service rehabilitation education could improve the quality and applicability of training to both for-profit and non-profit private rehabilitation. However, incentives for educators and students will be necessary for this to occur.

References

Bellamy, G., Rhodes, L., Mank, D. & Albin, J. (1988). Supported employment. Baltimore: Brookes.

Blackwell, T. (1991). The vocational expert primer. Athens, GA: Elliott & Fitzpatrick.

Bordieri, J., Riggar, T. Crimando, W., & Matkin, R. (1988). Education and training needs for rehabilitation administrators. Rehabilitation Education, 2 (1), 9-1 5.

Brabham, R., & Emener, W. (1988). Human resource development in rehabilitation administration futuristic perspective. Journal of Rehabilitation Administration, 11,, 124-129.

Buckley, J, Albin, J., & Mank, D. (1988). Competency based staff training for supported employment. In G. T. Bellamy, L. Rhodes, J. Mank & B. Albin, (Eds). Supported employment: A community implementation guide (pp 229-245). Baltimore: Brookes.

Cohen, J. & Pelavin, D. (1992). 1992 survey of personnel shortages and training needs in vocational rehabilitation. Washington DC: Pelavin Associates.

Commission on Rehabilitation Counselor Certification (1992, Winter). CRC: The Counselor. Rolling Meadows, IL: Author.

Deutsch, P. (1985). Rehabilitation testimony: Maintaining a professional perspective. Albany, NY: Matthew Bender.

Deutsch, P., & Sawyer (1986). A guide to rehabilitation. Albany, NY: Matthew Bender.

Fischer, J., Rollins, C., Rubin, S., & McGinn, F. (1993). The ethical case management practices training program: An evaluation. Rehabilitation Education, 7 (1), 7-15.

Gilbride, D., Connolly, M. & Stensrud, R (1990). Rehabilitation education for the private-for-profit sector. Rehabilitation Education, 4, 155-162.

Holland, J. (1990). The occupations finder. Odessa, FL: Psychological Assessment Resources.

Kaiser, J. & Brown, J. (1988). Ethical dilemmas in private rehabilitation. Journal of Rehabilitation, 54 (4), 27-31.

Kotler, P. & Bloom, P.(1984). Marketing professional services. Englewood Cliffs, N.J.: Prentice-Hall.

Levitt,T.(1986). The marketing imagination. New York: Free Press.

Lynch, R., Lynch, R., & Beck, R. (1992). Rehabilitation counseling in the private sector. In R. Parker & E. Szymanski (Eds.), Rehabilitation counseling: basics and beyond (2nd ed.) (pp. 73- 101). Austin TX: ProEd.

Lynch, R & T. Martin (1982). Rehabilitation counseling in the private sector: A training needs survey. Journal of Rehabilitation. 48 (3), 51-73.

Matkin, R. E. (1985). Insurance Rehabilitation. Austin, TX: ProEd.

Matkin, R. E. (1987). Content areas and recommended training sites of insurance rehabilitation knowledge. Rehabilitation Education. 1, 233-246.

Matkin, R. (1983). The roles and functions of rehabilitation specialists in the private sector. Journal of Applied Rehabilitation Counseling, 14 (1), 14-27.

Matkin, R. & Riggar, T. (1986). The rise of private sector rehabilitation and its effects on training programs. Journal of Rehabilitation. 52 (2), 50-58.

Menz, F., & Bordieri, J. (1986). Rehabilitation facility administrator training needs: Priorities and patterns for the 1980's. Journal of Rehabilitation Administration, 10, 89-98.

National Association of Rehabilitation Professionals in the Private Sector (1992). 1992-93 NARPPS national director. Brookline, MA: Author

Nadolsky, J. (1986). Ethical issues in the transition from public to private rehabilitation. Journal of Rehabilitation, 52 (1), 6-8.

Pacinelli, R. & Stude, E. (1991). Human resource development: Partnerships in rehabilitation education. Washington DC: George Washington University Regional Rehabilitation Continuing Education Program.

Parker, R. & Szymanski, E. (Eds.) (1992). Rehabilitation counseling: basics and beyond (2nd ed.). Austin TX: ProEd.

Renzaglia, A. & Everson, J. (1990). Preparing personnel to meet the challenges of contemporary employment service alternative. In F. Rusch (Ed.) Supported employment: Models, methods and issues (pp.289-300). Sycamore IL: Sycamore.

Ritter, S., & Leclair, S. (1990). The small employer disability management consortium as a case management and consultation alternative. NARPPS Journal and News, 5 (4), 15-24.

Rubin, S. E. (1993). Introduction to special feature on ethics. Rehabilitation Education, 7 (1), 2-3.

Rubin, S.E., Matkin, R.E., Askhley, J., Beardsley, M.M., May, V.R. Onstott, K.& Pucket, F.D.(1984). Roles and functions of certified rehabilitation counselors. Rehabilitation Counseling Bulletin, 27, 199-224.

Sales, A. (1979). Rehabilitation counseling in the private sector: Implications for graduate education. Journal of Rehabilitation. 45, (3), 59-61.

Stensrud, R. & Gilbride, D. (1992). Long term training grant in facilities administration. Funded by RSA 1993-1997.

Taylor, L., Golter, M., Golter, G., & Backer, T. (Eds.) (1985). Handbook of private sector rehabilitation. New York: Springer.

Vogenthaler, D., & Tierney, J. (1990). Assessing work-related economic damages after head injury. Missouri Lawyers Weekly, 4 (15), 1-3.

Washburn, W. (1992). Worker compensation disability and rehabilitation: An alert to claimants. Arlington, VA: CEDI.

Weed, R. & Field, T. (1990). Rehabilitation consultant's handbook. Athens, GA: Elliott & Fitzpatrick.

Weed, R. & Riddick, S. (1992). Life care plans as a case management tool. The Case Manager, 3 (1), 26-35.

Wehman, P. & Moon, M. (Eds.) (1988). Vocational rehabilitation and supported employment. Baltimore: Brookes.

Williams, J., & Fidanza, N. (1990). Ensuring the success of industrial rehabilitation programs: The role of the rehabilitation counselor in return to work. NARPPS Journal and News, 5 (5), 67-71.

Appendix

Student Competencies for a Bachelor's Degree in Facilities Administration

1. **General Personnel Management:**
   - Human resource management
   - Performance/productivity management
   - Personnel assessment and appraisal techniques
   - Staff training and development
   - Recruitment and retention of personnel
   - Risk management
   - Business planning and marketing
   - Supervisory communication skills
   - Labor relations
   - Psychology in business and industry
   - Group dynamics

2. **Professional Development:**
   - Sensitivity to disability issues
   - Orientation to not-for-profit business
   - Administrative theory
   - Fundamentals of management and organizational behavior
   - Organizational roles, functions, and operations
   - Organizational leadership
   - Managing organizational change
   - Principles of service organizations
   - Ethics in management and rehabilitation
   - Practical experience in rehabilitation facility administration

3. **Program Planning and Evaluation:**
   - Administration of rehabilitation programs
   - Rehabilitation service systems
   - Development and supervision of rehabilitation employees
   - Not-for-profit employee performance management
   - Casework management
   - Program evaluation
   - Worksite statistical applications
   - Research in rehabilitation

4. Fiscal Management:
   - Financial management
   - Public financing systems in rehabilitation
   - Fiscal/operations management in not-for-profit organizations
   - Budgeting procedures for middle managers

5. **Technical Systems:**
   - Personal computers and business software
   - Management information systems
   - Computer applications for people with disabilities
   - Making work site accommodations

6. **Public Relations:**
   - Individual and small group communication skills
   - Public relations
   - Community education
   - Professional and community relations
   - Community image definition and fund raising
   - Legislative and governmental relations in not-for-profits

7. **Employment Services:**
   - Facility based employment models
   - Community based employment models
   - Employer development
   - Consulting to employers
   - Financing employment services

8. **Serving People with Disabilities:**
   - Medical and psychosocial aspects of disability
   - History and nature of disability in America
   - People with disabilities in business and industry
   - Working with rehabilitation consumers and advocates
   - Legislation and regulations affecting people with disabilities
   - Barrier identification and Disability advocacy
   - Worksite accommodations and accessibility
   - Job analysis and redesign

Private rehabilitation as a discipline is changing and evolving based on forces at work on compensation systems. These forces include:

1. Changes in compensation systems, such as repeal of mandatory rehabilitation within Workers' Compensation in some states, merger of short term disability and long term disability insurance products, etc.
2. Americans with Disabilities Act.
3. Health care reform.

What is emerging in private rehabilitation is the concept of disability management, a combination of proactive medical and disability case management. These services may be provided by a combination of professional specialties, including nursing, rehabilitation counseling, ergonomic engineering, and a host of other related professions.

The extent to which rehabilitation counseling maintains a place in the newly emerging disability management concept depends upon the following:

1. Availability of supply of qualified professionals.
2. Professionals who have specific skills and competencies for disability management.
3. Role of disability management after health care reform.

Dr. Gilbride raises serious concerns about the ability of the current rehabilitation education system to meet the needs of private rehabilitation. His concerns include funding and recruiting issues and constraints on curriculum in regard to accreditation.

Dr. Gilbride suggests rehabilitation counseling education needs to expand the financial base so that it can become more responsive to emerging trends in private rehabilitation. In addition, developing flexibility in curriculum design is desirable to develop necessary skills that will be needed in the private sector.

I agree these are areas which need to be addressed. Failure to do so may affect the qualifications and supply of rehabilitation counselors for the private sector. As a result, services traditionally provided by the rehabilitation counselor (such as job analysis, job modification, and placement) may shift to other related professional specialties.

– Catherine C. Bennett

Dr. Gilbride has presented an excellent critique of rehabilitation education for both the private and public sectors in rehabilitation. Dr. Gilbride correctly observes that there is, "substantial disagreement existing among leaders and educators in the field of rehabilitation concerning how broadly a basic course should be defined" for training in the private sector.

The importance of being certified as a rehabilitation consultant has certainly added credibility to practitioners work in the private sector and the certification movement continues to gain strength and momentum. In addition to the three programs referenced by Dr. Gilbride (CRC, CIRS, CVE), a very strong interest has been displayed by professionals in becoming certified as case managers (CCM). It is expected that this strong interest in certification and eventual licensure by state will be part of the future.

With respect to Dr. Gilbride's observations regarding accreditation of the training programs by CORE, it is certainly true that graduates of CORE programs have a distinct advantage when applying for certification. On the other hand, I have always viewed CORE, along with RSA training funds, as part of the state/federal strategy to largely exclude developments in the private sector (with no malice intended). This observation is born out by the very slow and pedantic movement toward any resemblance of specialized training for candidates moving into the private sector and, more importantly, by the continuing "road block" of requiring stipend recipients to work only in the public sector following graduation. This clearly is a punitive and exclusionary move by RSA and the CORE credited programs.

Finally, Dr. Gilbride has correctly observed that there is a substantial interest and movement towards forensic rehabilitation by many within the private sector movement. Required knowledge and competencies can usually be obtained only through non-university related seminars and professional association conferences. Much more can be done by the university in formalizing these areas of required information for all masters candidates interested in moving into the private sector.

– Tim Field

Dr. Gilbride presents a realistic view of private sector rehabilitation in terms of current practice and expectations, and relates this to educating practitioners for work in the for-profit arena. An important delineation is made between private for-profit and private non-profit rehabilitation which results in acknowledging the divergence in job tasks and required skills and competencies of each group of rehabilitation professionals. This is an important point since many rehabilitation counselor education programs do not acknowledge these differences.

In contrast to other publications on the for-profit sector which have reflected limited employment environments, a full range of employment settings is identified in this manuscript. However, the primary focus of rehabilitation educational training programs tends to reflect public and non-profit settings due to government funding for these areas. The need to offer training in for-profit rehabilitation is also necessary but does not

have the funding support to provide incentive for development of such training. A market-driven approach, as described in the manuscript, could benefit not only curriculum development but funding development, as well, in providing a financial base in terms of scholarships or assistantships for deserving students and consultation for faculty. In addition, a full-fledged public awareness campaign could be undertaken by various private sector professional rehabilitation organizations and educational institutions to promote awareness of for-profit employment opportunities. Large employers might also see the relevance of participating in such a campaign.

Another implication for the future of for-profit rehabilitation is the effectiveness of vocational rehabilitation service delivery in regards to workers compensation and other insurance cases. Professionals working in this area must be provided training on issues specific to provisions of insurance systems so that adequate documentation of their effectiveness is presented. In conjunction with this, program evaluation systems should be implemented and maintained to assure effectiveness and efficiency of rehabilitation services through appropriate outcome measures.

– Juliet H. Fried

Dr. Gilbride points out very clearly that, in general, rehabilitation education programs are not responsive and sensitive to the changes in the rehabilitation industry as a whole. Both the private for-profit and private non-profit sectors have evolved over the years and their educational needs have altered.

Rehabilitation education programs must therefore grow with these new demands. At the same time, however, practitioners and their respective professional associations such as National Rehabilitation Association (NRA), National Association of Service Providers in Private Rehabilitation (NASPPR) and National Association of Rehabilitation Professionals in the Private Sector (NARPPS), must assert themselves to effect the Council on Rehabilitation (CORE) and the Commission on Rehabilitation Counselor Certification (CRCC), the two "primary organizations designed to improve the quality of rehabilitation training and practice". To accomplish this, private rehabilitation, particularly for-profit, must begin to address its own identity crisis.

As a profession, private rehabilitation is still relatively new. Practitioners are constantly struggling with ethical dilemma, as indicated by Dr. Gilbride. The question of "who is the client?" is asked not just by the profession itself, but also being challenged by other players in disability benefit systems and especially in forensic rehabilitation arena. The lack of research data and the lack of documentation further compound this image or "public relations" problem. Private rehabilitation, as an industry, should and must start to tackle these issues. Again, this is where the leadership in professional associations, CORE and CRCC will play a major role.

– John W. Lui

Dr. Gilbride presents a thorough exploration of various training-related issues as they impact on the private rehabilitation arena. Certification, accreditation and forensic issues are discussed, with numerous conclusions and recommendations for further consideration summarizing this article.

From the information presented here, it is clear that rehabilitation counselor education programs need to work towards expanding their focus of training in order to include the wide range of settings where our rehabilitation counseling students are employed. With RSA funding having been (and still being) a major funder of rehabilitation counselor training programs, it is understandable that the focus of graduate programs have been on public sector work. However, with the growth and the demand for qualified personnel coming from the private sector, it is time for educational institutions to recognize the demand, and offer training to students that will result in profitable, challenging careers in the private sector.

As a Commissioner on the Commission for Rehabilitation Counselor Certification, I share the author's recognition of the importance of the CRC credential in the for-profit environment; it is my strong belief that certification is a way of measuring the value and the importance a professional places in their own "professionalism", by submitting to the application process, by sitting for a national examination, and by maintaining their certification (and also their knowledge-base) by certification maintenance.

It is true that the phasing-out of the bachelor's degree category will result in tighter standards for obtaining certification, but I do not see it having as significant an impact on the labor pool as is indicated by the author. In fact, while approximately 30% of the applicants at the close of the June 1992 cycle had bachelor degrees, the number of applicants in this category was unusually high due to the plans to phase out that category. Historically, the figures are less than 15% of applicant pool possessing a bachelor's degree.

Expanding the focus of graduate training programs, and offering students a wider range of options at the conclusion of graduate training, can only help the educations institution, the future professional and the private rehabilitation field.

– Patricia Nunez

The education of vocational rehabilitation counselors and vocational evaluators for private sector rehabilitation has been anything but forward thinking. There appears to be a perception with most universities that traditional public rehabilitation utilized in a state rehabilitation agency or program is the only form of rehabilitation worth teaching. This is unfortunate for the graduates of these programs because the likelihood of them working for any length of time in the public sector is diminishing each day.

Working in private rehabilitation sector at some point in their career, however, is extremely high.

With the advent of the Americans with Disabilities Act, health care reform, spiraling costs in workers' compensation, and other changes which affect American business, it is reasonable to expect that business will rely on qualified rehabilitation professionals to address their needs. The difficulty is, that relatively few rehabilitation professionals have formal education in business related issues and needs. Those that do, have little exposure until they complete an internship with a private rehabilitation company, are employed by one, or are employed directly by a business or industry to provide rehabilitation services and/or deal with disability management.

Working with employers in business or industry is much different than working with the traditional state vocational rehabilitation concerns. Rehabilitation professionals, whether working in public or private sectors, need to know the differences and must be able to utilize their skills appropriately.

In addition, rehabilitation professionals in both sectors need more information and training in forensics. Because of rising litigation, whether it is Social Security, workers' compensation, personal injury, or disability discrimination the possibility of one being called to testify in court is very high. Again, the current curriculum in most universities do not offer any exposure in this area. As a result, the rehabilitation professional learns these skills through on-the-job training.

Dr. Gilbride addressed these issues in his action paper. The recommendations which he and the review group proposed were well thought out and will hopefully be implemented. If they are not, rehabilitation professionals who graduate from our universities will continue to be inadequately prepared for their profession.

– Jeffrey J. Peterson

Dr. Gilbride articulately outlines the current issues in educating practitioners for work in the private sector. Apparently correlated with funding and the needs of the population served, non-profit rehabilitation has emphasized consulting and disability management services. Dr. Gilbride explains how this divergence has resulted in the development of job tasks with vastly different skill requirements. Individuals employed in non-profit rehabilitation settings with few exceptions require only short term specialty training or non-degree programs. Dr. Gilbride makes a cogent argument for the development of training programs for paraprofessionals to be employed in private not-for-profit rehabilitation settings.

Rehabilitation professionals in for-profit settings have increasingly diverse employment options. This diversity presents challenges to the traditional graduate level training available through Rehabilitation Services Administration (RSA) funded master's degree programs in rehabilitation counseling. Required to match the missions of the State/Federal vocational rehabilitation program, the RSA funded graduate programs have focused upon competencies required in the public and non-profit sector. Similarly, Dr. Gilbride's paper reflects that CRC and CORE, the same organizations which have successfully promoted rehabilitation counseling as a profession and professional training, to different degrees, need to address relevance for private-for-profit professionals.

Minimally, the addition of graduate course work in providing expert testimony, life care planning and ethical problem solving through rehabilitation departments would assist rehabilitation professionals address these topics with a uniform perspective. In my experience, possessing a basic understanding of these topics before entering proprietary rehabilitation would facilitate the mentoring process required to acquire these skills and reduce staff turnover.

Regardless of the type of training, the importance of addressing the needs of working adults cannot be overemphasized. Flexible, relevant and timely curriculums can only enhance the quality of services provided by private sector practitioners.

Stephen A. Zanskas

The following is a summary of the recommendations and implications for action as they relate to the discussions of chapters One & Two.

These recommendations were developed by an individual work group and the style of presentation reflects their own format along with implications for action.

The following recommendations will serve to address the changing needs for rehabilitation education and training for the next decade and beyond. The recommendations call for a total reexamination of the manner in which rehabilitation education is currently and traditionally achieved. Changes will be required primarily due to the significant changes in our society with respect to developments in both the private and public sectors of rehabilitation, emerging national health care policy, spiraling costs for both workers' compensation and health care, and special needs for managed health care.

Service Delivery

1. Public rehabilitation programs should serve private clients through a merging of public and private programs brought about by anticipated changes in health care reform.
2. There should be a national registry of qualified rehabilitation providers and independent contractors, including graduates of the rehabilitation training programs.
3. Programs for rehabilitation service delivery should be by "choice" of the client.
4. Funding strategies for the university programs should be broadened to include training needs for independent contracting and client choice service delivery programs.

Training

1. The Council of Rehabilitation Education (CORE) should expand curriculum to include private sector issues related to all service delivery systems.
2. Professionals associations should be more active in articulating the training needs of their members.
3. Graduate stipend recipients should be required to "pay back" to any service delivery system.
4. Curriculum changes are needed in areas of, for example, business and industry, job analysis and labor market information, compensation programs, legal and forensic issues, insurance and disability management.
5. A future national conference of the National Council on Rehabilitation Education (NCRE) should focus on the merging of public and private sector programs.
6. Current faculty are encouraged to expand their awareness of insurance rehabilitation and case management issues as part of their continuing education, with opportunities for innovative research and writing.
7. The Rehabilitation Education Journal should have a special issue directed toward public and private sector rehabilitation concerns
8. Continuing education programs are needed for more "lifelong education" for all professionals in the broad field of rehabilitation -- to be sponsored by universities, business and industry, professional organizations, and others.

Research

1. The National Institute on Disability and Rehabilitation Research (NIDRR) should establish a Research and Training Center for "Rehabilitation in the 2lst Century -- the coming together of public and private sector rehabilitation."

2. Major organizations (CSAVR, NRA, NARPPS, NCRE, CORE, and others) should collectively and equally sponsor an independent study group to address the issues related to the merging the public and private sector rehabilitation.

Legislation

All recommendations listed above would be addressed by a variety of funding and legislative sources in reinforcing needed changes.

Chapter Three

Insurance Issues and Trends: A Focus on Disability Management including Rehabilitation

Patricia M. Owens

Introduction

This paper presents broad-ranged insurance issues and trends in the context of work place disability management (DM). DM in the work place applies to both insured and employer self-insured disability benefit programs. Rehabilitation is an important part of disability management, and practitioners must view their role (and be trained to carry out this role) in the larger context of comprehensive DM.

As in any developing field, the prediction for the future of DM is extensive and intensive change. Trained rehabilitation professionals can "catch the wave" and help shape this change.

Organization of The Paper

Disability and work place DM are defined. Next, key aspects of three workplace disability programs (ie) Workers' Compensation (WC) programs for illness and injuries arising out of and in the course of employment, non-WC disability programs and the Social Security (SS) disability program are reviewed and related to DM.

Rehabilitation services are then discussed from the viewpoints of specific DM participants and payors (insurers, employers and employees).

The paper ends with a brief discussion of four change agents - The Americans with Disabilities Act (ADA), Health Care Reform, Twenty-four hour medical and disability coverage, Social Security Disability Program Reform, - and their likely bearing on DM and the private rehabilitation professional.

Patricia M. Owens, Vice-President of Disability Programs, UNUM Insurance Company of American, Portland, Maine.

Disability Management

The Disability Risk:

A working definition of disability and a basic understanding of the disability risk is essential to explore the broader issue of work place disability management.

Disability occurs when a medical (physical or mental) condition impairs a person's capacity to function at a prescribed level (with or without accommodation). Work-based definitions of disability can require that a person be unable to perform some or all of the functions of his or her own usual occupation or, they can be more stringent and require that a person cannot perform the functions of any occupation. For WC, a person may be disabled and qualified for benefits when a work-caused accident or injury reduces their earnings capacity because of a loss in the ability to function. Often this reduction in earnings capacity is quantified by a payment schedule. For example, a finger garners so many dollars and an arm more dollars. The degree of the loss is often the source of litigation. The point here is that definitions of disability for compensation in lieu of wages vary.

The following statistics help us understand the likelihood of someone being disabled:

> In 1989, 1 in 7 Americans reported physical and mental conditions that interfere with life activities.(1)
>
> In 1990, 14.2 million working age persons reported that they were limited in that they were limited by some disability that interfered with work. (1)
>
> In 1991 there were 8.4 work-related injuries per 100 full-time private sector workers, 3.9 lost work-day cases and 86.5 lost work days. (2)

Disability claims rose in 1992. Both SS and UNUM Life Insurance Company report increases in incidence and duration. In 1992, SS Incidence was 5.4 per thousand (11). UNUM Life Insurance data covering 5 million lives indicates that there was a 23% increase in disability claims in 1992 over 1989.

Leading causes of claim for SS are - 1. Mental, psychoneurotic and personality disorders, 2. Cancer, 3. Circulatory System.(20)

General Accidents are the highest cause for UNUM followed by cancer, heart conditions and back disorders. Six % of claims are for psychiatric conditions and on the rise.

Work disability may be partial (some work can still be done) or total (essential functions of work cannot be performed at all). Disability may last for only a few days or may be permanent. In the western world, public and private disability compensation systems have evolved to provide income for persons whose disabilities keep them from working. Deborah Stone, in her definitive book, *The Disabled State*, discusses payments for a disabled condition in the framework of redistributive justice. In the U.S. both public and private funds are set aside when a person's medically determinable physical or mental impairment of function inhibits their ability to earn a wage. Employers pick up a large portion of the tab.

Disability involves more than the severity of an impairment that reduces function and precludes work. It involves many personal, socio-political and economic factors. Although the length of this paper does not permit an in depth discussion of the spectrum of contributing factors, it is important to acknowledge that disability designation, frequency and duration are driven by a complex system of interactive phenomena.

Defining Disability Management(DM)

DM is a term that describes actions and programs to control the human and dollar costs of disability in the work place. These actions center on the costs of the disability both at the individual and organizational level.

DM programs reflect the employer's overall human resource philosophy and strategy. Employers who need skilled workers for complex jobs and place a high value on the people who work for them will provide more in benefits to attract and retain employees. In such an environment, DM is aimed at preventing disability but, when it inevitably occurs, providing accommodation and adequate compensation to replace lost wages resulting from reduced function. These employers emphasize rehabilitation and return to work.

Conversely, DM may be minimal if employers have a human resource philosophy that accepts high employee turnover especially when jobs do not require high skill levels. In this setting, vacancies can easily be filled by full-or part-time replacements. When an employee can't work because of sickness or accidents, they usually rely on public programs for protection. If WC is not involved, employees with disability are terminated when they are unable to perform their essential job functions and use up their allotted (if any) sick days.

The size of the employer is an important factor in the magnitude of DM. DM initiatives of smaller (under 500 employees) employers may only include short-term and/or long-term benefits provided through an insurer who includes limited DM service. The smaller the employer, the more informal and low-budget the DM programs may be. (A fairly recent occurrence is the local business consortium. These "business groups on health", are springing up in communities throughout the US, while originally geared to rising medical care costs and medical care issues, are also considering pooled resources for dealing with disability issues including return to work and ADA responsibilities.)

A Disability Management Model

The Organization's Philosophy and High-Level Commitment

DM flows from a precisely stated organizational philosophy and high level organizational commitment to a portfolio of programs and services. Benefits handbooks are most often used to communicate employee health, medical and disability benefit and management programs and how they interact to all employees.

The most comprehensive DM philosophy takes a position on work safety, healthy life styles and includes disability prevention and Employee Assistance Programs (EAPs). Effective DM provides for adequate benefit levels, fair claims decisions - including appeals, early intervention services, job modification and reasonable accommodation. Medical and rehabilitation services support maintenance or restoration of function and return to work.

Linked Absence Policy

Good DM requires a clear-cut absence policy including absence for sickness and disability. Employees must know when and how they will be paid for absences. Definitions of disability, disability compensation system provisions and processes, the roles of management, employees and third-party providers must all be clearly explained.

Employee rights and obligations regarding disability, along with employer responsibilities under the ADA should be included. Special industry job requirements and restrictions and drug-testing policy are often pertinent and should be stated.

Information Systems

Effective DM is built on an information system that captures data, provides information and reports on disability related issues such as benefits costs, types of illness and accidents across programs so that targeted action can be taken. The most advanced system will provide for cost benefit analyses. Indirect costs of disability, such as loss

of productivity and worker replacement costs need to be factored in. For larger firms, data and information are produced at the division level as well as in the aggregate for the company so that distinct problem areas can be identified and rectified.

Benefit Plans:Incentives and Disincentives

All disability benefit plans need incentives to encourage return to work. These can be financial in nature, with benefit rates being at some level below take-home wages. However, other work place factors can provide incentives or disincentives for work vs. disability. It is important that employees consider work a more attractive alternative than disability. It is not always financial incentive that tips the scale for keeping an employee at work or returning them to work. Personal relationships at work and at home may be involved. Early return to even partial duties can help prevent an employee from developing a disability mind-set.

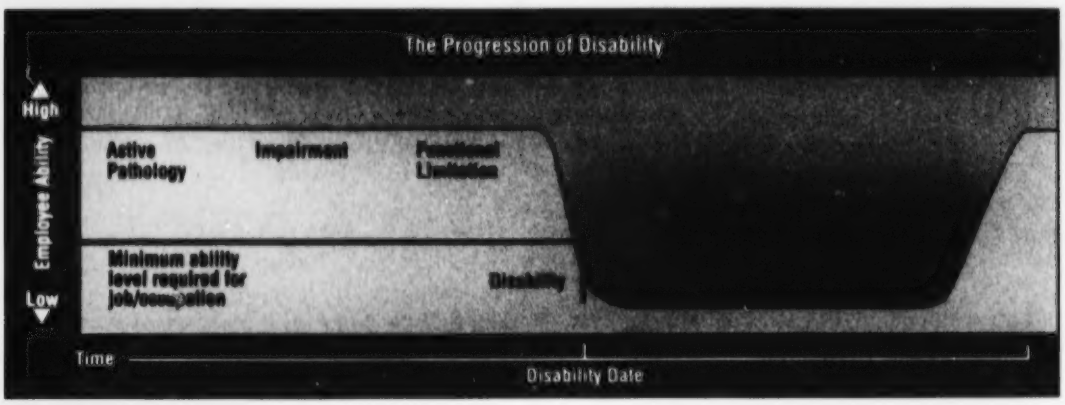
automobile accident and other casualty insurance payments in addition to the Social Security and WC offsets more frequently encountered.

Settlements

Settlements, i.e.- payouts of disability benefits are viewed by some as a DM strategy. Settlements provide a different payment option for disability claimants. The payouts which may be in a lump sum or a series of payments, are awarded in exchange for the claimant waiving future rights to benefits.

This practice lowers the overall costs for employers and insurers because the settlement is generally lower than the total of the payments that would be paid. Settlements release money that employers and insurers hold in reserve to cover the projected claim duration and this benefits the payor.

Settlements are advantageous to the employee/claimant



There should be a serious attempt to identify and understand both individual and organizational incentives and disincentives to return to work. Funding levels, plan designs and administrative oversight are all important.

Integration of Programs and Cost-Effectiveness

Insurers who underwrite employee disability benefits programs (both Workers' Compensation and non-occupational illness and injury benefits) and third-party administrators or employers who self-fund and self-administer disability related programs look for ways to manage disability and control costs. They have singly and jointly become more sophisticated in understanding program integration. This means making programs work together in everyone's best interest to minimize the full cost of disability, including medical care costs, and to achieve maximum cost benefits from DM initiatives.

One of the main objectives of integration, to manage overall benefit levels to provide financial incentives for return to work was discussed earlier, but it bears repeating in this context. Some disability benefits now integrate with

because they get a sizable sum at one time which can provide for greater flexibility in retiring debt or investing. Settlements appear to be on the rise especially in disputed or "gray area" claims.

WC settlements are referred to as Compromise and Release (C&R) agreements. John F. Burton indicates there are no national data on these agreements. (10) A study by Burton with the Workers Compensation Research Institute could not establish whether C&R agreements increase or decrease the costs of WC.(9) Burton says "I am not sure whether ....C&R agreements...are increasing...(although my suspicion is that...(they) are". He also believes that they increase the overall costs.(10)

Managing Disability For Individuals

In a model DM program with a clear philosophy, organizational programs and high level commitment, there is still a need to focus on the individual. When an individual becomes disabled, individuals and their families need to be able to rely on clear, fair and consistent guidelines and practices. Equitable claims require on credible evidence of the medical condition

showing what a person can or cannot do as a result of a functional impairment. Systematic, interested decision-making and follow-up by the claims payor and the employer will be present. Identifying when maximum medical recovery occurs and taking actions to return persons to work in their own or other jobs are fundamental. Return to work is the optimal goal; rehabilitation potential must be considered and realistic rehabilitation begun as early as possible based on the individual's needs.

Viewing individual disability as a continuum, DM actions for an individual may occur at a variety of points. (See Chart below, reprinted with the permission of UNUM Corporation.)

The Workers' Compensation System

Program Design

The Workers' Compensation system began in the early 1900s and now has separate programs for each of the fifty states and the District of Columbia. Under these programs, employers pay the costs of all work connected injuries regardless of fault. Each state is responsible for its own program, but each program provides the same basic type of benefits. A worker must show a connection between the injury and work before any benefits can be collected.

Benefits include a weekly amount (usually two-thirds of wages subject to a maximum) paid while the worker is out of work or until maximum medical improvement (MMI) has been reached. If after MMI the person still has permanent impairment but is not totally disabled, compensation will be due in the form of permanent partial payments based on a schedule for specific impairments, the loss of earning capacity, or actual wage loss. If after MMI the person is totally disabled, payments are determined accordingly. Therefore indemnity payments may be made for temporary disability, permanent partial disability and permanent total disability. Each state has a different way of computing the indemnity payments, which may be paid in a lump sum or in increments.

"According to the theory of workers' compensation, the worker was not supposed to benefit from the accident, but was entitled to a cash amount designed to preserve living standards." say Berkowitz and Berkowitz, 1991. (7) (Note: survivor benefits are also available.)

Medical Benefits

In addition to the indemnity payments, WC pays for full medical care without any limits for work related injuries. Again quoting Berkowitz and Berkowitz, the worker is entitled to "the medical care necessary to reach the point of maximum medical improvement." (7) Medical benefits are the fastest growing segment of WC costs and this has led to a variety of reform ideas, especially an emphasis on managed medical care.

Rehabilitation

Berkowitz(90) and Berkowitz and Berkowitz (91) maintain that rehabilitation has always been an intent of the WC program. The goal of rehabilitation is to restore workers to their pre-injury abilities, not to improve their pre-injury work capacity. Formal mandated programs grew in the 1970s, with California in the forefront. They began to weaken in the 1980s and 1990s, mainly because of their cost and lack of documented cost effectiveness (as measured by reduced WC costs overall and/or earlier return to work.) Another reason cited for the failure of WC rehabilitation was increasing litigation, which could encourage an employee to stay out of work while pursuing a settlement.

Interaction (Offsets)

WC is the first payor but integrates with Social Security. In most states Social Security is offset by WC benefits, but some states have a reverse offset so that SS is the first payor. Other STD and LTD benefits integrate or pay only contract amounts that exceed WC payments. As an example, for one large company, 75% of the STD payments also involve WC. This happens when STD payments are at a higher replacement rate, to cover a WC waiting period and when the nature of the work causes frequent WC claims.

Funding Mechanisms

The purchase of insurance to cover WC cost is the most common funding method. Some states permit employers to self-insure, but these employers must meet strict eligibility standards, mainly financial criteria. (Self-insuring employers substantially increased their share of benefits from 12.4% to 20% from 1960-1990. The relative share peaked at 20.5% in 1983.) (10)

Most States provide for price control. Premiums are based on book rates developed by a rate-setting organization. All carriers must use these rates in selling WC policies. While adjustments are permitted, all carriers are subject to the same type of rate adjustments based on like formulas. Carriers compete on the basis of dividends and service, among other factors.

There are two distinct (but not equal) WC insurance markets, Voluntary and Residual. In the voluntary insurance market, carriers believe the premium they are allowed to charge allows them to meet profit objectives. Employers are willing to pay these rates. Therefore, insurance carriers "voluntarily" market to employers.

When state insurance commissioners will not approve rate increases to acceptably profitable levels, carriers may no longer offer voluntary insurance to some industry segments. When employers cannot get voluntary coverage they are forced into the residual insurance market established by most states to provide risk relief.

Residual markets are on the rise. These state-run markets operate like assigned risk pools for automobile insurance. Insurers offer voluntary insurance only to selected industries. Employers in other industries may be assigned to a state-operated pool or to a specific carrier. All losses over and above premiums collected from these pooled employers must be shared by insurers doing business in the state. Self-insured employers usually do not have to contribute to the residual pool.

There is now some movement away from price controls and other state mandates. Deregulation began in the early 1980s. So called "open competition" allows insurance companies to determine rates. Arkansas, Colorado, Connecticut, Georgia, Hawaii Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Minnesota, New Mexico, Oklahoma, Oregon, Rhode Island, South Carolina, Texas, and Vermont have some form of open competition. Maine law includes reference to open competition but most of the premium is in the residual market. It is interesting to note that Moves to more open competition have been made in the hopes of lowering WC costs for the employer and thus encourages insurers and employers to look for ways to better manage risks, (eg) DM.

Program Costs

According to John Burton, data for 1991 and 1992 suggest that WC costs have increased on the average of 8% a year since the beginning of the decade. To put this in perspective, costs increased to 18.6 % between 1971 and 1979, slowed to 4.3% between 1979 and 1984, and grew 13.3 % a year between 1984 and 1990. For 1992, Burton estimates that the WC expenses would be 2.57% of payroll and that WC costs will accelerate in 1993. (10) When viewed historically, the rise in WC rates can be linked with a variety of factors including increased personnel, work place accidents and higher benefit levels. Increase in medical costs have been a major contributor to the overall upward spiral. Other factors include increased litigation and greater use of compromise and release agreements. (10)

DM and Workers' Compensation

It is clear that the Workers' Compensation system provides a fertile field for DM. In fact, many argue that loss control, safety and prevention activities trace their beginnings to efforts to control WC costs.

Insurers and employers understand the need to encourage safety at work and to prevent injuries before they occur. Safety equipment, work site modification and self managed work safety teams were among the first DM activities, all generated by WC cost control strategies.

In a three-year collaborative research project, Hunt and Habeck (12), using a random sample of 220 Michigan employers from seven industries, correlated differences in employer DM with disability outcome measures. The study took into account differences among industry types. Employer programs were studied from an organizational perspective seeking out wide-ranging interactive programs including safety intervention to prevent the occurrence of accidents and disability, early intervention to seek out disability risk factors and coordinated DM services for cost effective restoration of function and return to work.

The measures of the effectiveness or consequences of the employer interventions used by Hunt and Habeck, were the incidence of work-related disability, the duration of disability and the total number of lost workdays. Successful employers, identified via the statistical analyses, were visited. These companies were generally found to be advanced in safety efforts and very active in injury management. They had implemented at least some form of return-to- work programs. The study demonstrated that companies which employ progressive wide-ranging DM have been rewarded by disability prevention and lower WC costs.

Employee Disability Benefits, (Non-WC)

These benefits generally include medical benefits, salary continuation for absences due to sickness or accident, short term disability benefits and long term disability benefits and are described categorically.

Medical Benefits

There are no definitive data sources that relate the availability of non-WC medical benefits to salary continuation, short-term disability (STD) or long-term disability (LTD) benefits offered by employers. Data indicates that smaller employers are least likely to offer medical benefits and many do not. Most employers who offer formal salary continuance, STD or LTD programs when queried, indicate that they provide at least minimal medical benefits. Few employers, large or small effectively link medical and disability benefits for prevention or early recover. However, there is growing awareness of the effect on each program has on the other in terms of prevention and return to function.

Salary Continuation and STD

Program Design

Many employers provide some type of sick leave or salary continuation at 100% of earnings for short-term absences or incidental time off because of minor illnesses and/or to see a doctor. These may be informal arrangements and vary based on industry, seniority, type of job or industry as well as other benefit programs that may begin paying after a contractual elimination period.

STD plans are more formal and typically begin paying benefits after salary continuation or sick pay has run out or on the first day of hospitalization. Some STD plans are provided in lieu of sick pay after a short waiting period.

STD plans generally replace 40% to 70% of earnings but can replace as much as 100%. Benefit periods range from 30 days to six months. Roughly 90% of employees eligible for STD benefits return to work within eight weeks or less.

Integration (Offsets)

There may be integration with other benefits, especially with WC. For many firms, non-WC disability is the dominant or sole occurrence, partly because pregnancy can be the largest cause of STD claims. Because of the short-term nature of their disability, those eligible for STD benefits are usually not entitled to Social Security. Some employers offset for personal injury settlements.

Rehabilitation

Since most short term disability remits with little intervention, systematic rehabilitation is not frequent. However when early intervention is a DM goal, employers and insurers seek out

potential LTD claims during the STD period and begin early case management including rehabilitation.

With a six month (or longer) STD (or salary continuation) eligibility period, rehabilitation may be considered and is usually made available based on an assessment of potential for success measured in overall cost savings. Rehabilitation may also be considered as part of reasonable accommodation under the ADA.

Funding Mechanisms/Coverage

STD is often funded by an employer by purchasing insurance. Self funding (with third party administration) is popular with larger employers because the incidence of disability is predictable and costs can be accurately budgeted. When the employer is paying for the benefit, self-insurance, especially if self administered, can seem less expensive because there are no third-party premiums or fees.

With the defined contributions as opposed to defined benefits on the rise, employees may have to make their own choice about STD coverage. They have a limited employer provided benefit and they must decide how to use it. Or, employees may be offered an opportunity to enroll in a plan at their own expense.

The larger the company, the more likely it is to have a formal STD plan. Department of Labor publications indicate that 89% of companies over 100 employees have a formal plans while only 59% of companies with less than 100 employees do so. (15) (16) In unionized companies, there may be several plans depending on bargaining units.

Long-Term Disability Plans

Program Design

LTD plans pay benefits for an extended period, often to age 65, depending on the definition of disability. Generally these benefits pick up where STD benefits end. Earnings replacement is about 60% of pre-disability earnings, up to a maximum dollar amount. While large companies may self insure, most have a third party administrator. Most small to mid-size businesses and many large businesses rely on an insurance company to assume all or part of the risk.

There are a variety of plans available with definitions of disability that change after the initial period of disability. For the first two years of employee eligibility, LTD plans usually define disability as the inability of the employee to perform the functions of his or her own occupation because of injury or illness. After two years, the definition becomes more stringent, and the employee must be unable to perform the functions of *any* occupation.

Partial and Residual Payments

In LTD partial or residual benefits which encourage return to work even when a person cannot do the full functions fully are increasingly common. (Note: partial disability may also be a provision of some STD plans). These provisions allow persons to get wages for the work they do and collect benefits up to a specified cap, usually based on prior earnings. Generally there must be at least a 20% reduction in pre-disability earnings for benefits to continue.

Rehabilitation

Most LTD benefits programs, insured or self insured, consider rehabilitation. Large employers and insurers may have their own in-house rehabilitation specialists. Others rely on third-party providers on a fee-for-service basis. There is usually a screening matrix for rehabilitation referrals will be made. Screening criteria include employee motivation, in-house job availability vs. rehabilitation for out placement is feasible. The final decision often turns on the cost of rehabilitation vs. the cost of continued benefits, in addition to job availability. At this time, ADA also plays a part in the process. Both employers and insurers are looking for measures of cost effectiveness measures which, unfortunately, many rehabilitation professionals are unable to provide.

Integration (Offsets)

LTD plans generally integrate with Social Security and Workers' Compensation. In fact, insurers and employers count on this integration or offset to help defray costs. As indicated earlier, some employer plans offset for personal injury payments.

Funding Mechanisms/Coverage

Employers often provide LTD as a fully funded benefit either through insurance or by self funding. The larger the employer, the greater the likelihood of self-funding. Most smaller employers (500 or less employees) insure the benefit. Employers with as many as 10,000 employers may choose to insure part or all of the risk because the incidence is more unpredictable and the duration can be very long and thus expensive.

Again, as with STD, the move toward defined employer benefit contributions means that employers may offer LTD benefits but the employee has to choose them over some other benefit, or pay for the coverage.

Department of Labor statistics indicate that 19% of companies with 100 or fewer employees have long term disability programs. Of companies with more than 100 employees, 45% have a long-term plan.(15) (16) The observations earlier about STD with regard to employers and unions also apply here.

Individual Disability Coverage

Some employees and self-employed persons have individual disability income insurance. Earnings replacement averages 60% to 70% of pre-disability income but can approach 80%. The individual nature of this coverage, coupled with high-income replacement levels and a position of no offsets for other programs, makes it especially attractive to highly compensated professionals as well as a supplement for corporate executives. Disability is primarily defined in terms of inability to perform the duties of one's own occupation for the entire benefit period, usually until age 65.

Program Costs (LTD-STD)

The 1989 annual costs for short and long term disability exceeded $87 billion, while medical expenses for disability-related conditions added another $80 billion (Berkowitz and Green 1989) (17) The growth rate is unclear but an 8% to 18% rate is commonly used. Various factors effect this growth rate including the number of newly covered employees.

DM and Non WC Employee Benefits

As with WC, organizational and individual costs of disability mandate better and more humane management of disability in the work place. The goal of DM cost savings is prevention where possible through EAPs and other wellness programs. When disability does occur, the aim is to lower the employer's total cost by early intervention in the disability continuum to keep employees at work or return them to work. DM efforts aim specifically at accurate, consistent documentation of disability, restoration of working capacity and return to work through a variety of interventions.

There is less litigation in the non-WC arena, so there may be more opportunity for effective return to work and ultimate cost savings. When employees buy their own disability coverages, there may be different motivations to respond to disability management programs or for employers to push them. This is an area that needs further study to determine its effect on disability management.

The Total Cost of Disability Study

In 1991 and 1992, I coordinated a research project for UNUM Life Insurance Company of America. (Researchers included Monroe Berkowitz, James Chelius, David Dean, Donald Galvin and Sara Watson.)

In this 12-employer case study, we found that disability costs, excluding medical costs for non-WC but including WC medical costs, averaged just over 8% of payroll; 4% in direct costs (benefit payouts and administration); almost 4% in hidden costs (lost productivity, replacement rates, poorer quality calculated in relation to lost workdays and average salary of absent employees); and slightly less than 1% in DM costs for programs to prevent and reduce disability. From other data we know that private disability costs are growing at a rate of at least 7% a year. The average dollar cost per employee in the study was $2,285. (Chelius, Galvin and Owens, 92) (18)

The study documents the increased cost of medical care for persons filing for disability claims. In one company, medical care costs for persons on disability were 7.4 times higher than non-disabled employees. In another company, costs were 16.5 times higher. Think of the potential for medical cost savings when disability can be prevented.

The Social Security Disability Program

The Social Security disability program has its own special blend of political, social, legal and judicial underpinnings. This discussion centers on the insured Social Security Disability Insurance [SSDI] program as opposed to the needs-based program Supplemental Security Income [SSI] program). While SSDI is less than 50 years old, it has, like the Social Security System, undergone incremental change (read expansion). The Congress, courts, Presidents, disability advocates and program administrators have all worked their will on SSDI.

Many SSDI observers have noted what is termed "the pendulum syndrome" of the SSDI program. If we look at 100 Social Security claims, 30 may be clear-cut denials and 30 clear-cut allowances, and 40 are equivocal and require judgment. The decision on the 40 may go either way especially over time, as the underlying payment philosophy changes.

The 1992 incidence rate is expected to be about 5.4 awards per 1,000 insured workers. (20) This is the highest rate since 1978. In the absence of corrective legislation, the assets of the DI Trust Fund will be exhausted late in 1995, due to higher-than-predicted incidence rate coupled with longer durations of disability.

The House Ways and Means SubCommittee has chartered a study by the National Academy of Social Insurance to review disability policy and the Social Security disability system from a broad public policy perspective, including its relationship to other public and private programs. This study arose from concern about current structure and cost.

There are three main areas of interest in comparing the Social Security program with WC and employee benefits: - the definition of disability, SSDI's position as first payor in the pecking order of integrated disability benefits, and the provisions relating to rehabilitation and return to work, including the oft-debated incentives and disincentives.

The Social Security Definition

The definition of disability for Social Security payment is rigorous. Paraphrased, a person must be so impaired by reason of a medical condition that, given age, education, and work experience he or she cannot perform the functions of any job that exists in the national economy. The disability must be expected to last a year or result in death. There is a five-month waiting period from the onset of disability to payment. Other disability benefit programs are activated earlier, many with a less severe condition.

Social Security As First Payor

Social Security payments are reduced by Civil Service retirement and disability benefits as well as WC in most states. Since for employee benefit programs, SSDI is the first payor, both employers and insurers often require their claimants to exhaust all levels of appeal to gain SSDI and employers and insurers frequently pay for legal representation.

After two years SSDI beneficiaries get Medicare which can become first medical insurance payor for disabled employees who are no longer considered actively employed. (Transfer to Medicare accounts for big medical costs savings for insurers and employers.)

Social Security and return to work incentives

While SSDI does have return to work incentives for beneficiaries -- a) trial work periods when a person can work and still get SS benefits and, b) re-entitlement for SS beneficiaries who fail in their return to work attempts, -- few SS beneficiaries do return to work and leave the rolls. Actually less than 1% of people leave SS because of return to work. (Note, this tendency of SS beneficiaries to stay on benefits may also contribute to longer incidence for persons collecting under private disability plans if they are also entitled to SS.)

Rehabilitation opportunities through state vocational rehabilitation agencies have been a part of Social Security since its inception. Reimbursement to state vocational rehabilitation agencies occurs only when the SS beneficiary stays at work for at least nine months. With the strict definition of disability and the reimbursement method it is easy to understand reluctance on the part of state agencies to routinely work with this population.

Social Security conducted many demonstration projects over the years to try to improve the return to work successes of its beneficiaries. Tests of private and non-profit rehabilitation providers have also been without real success. SS is currently conducting early case management experiments dubbed "Operation Network". Some of the cases are managed by SS employees in the district office, some by state rehabilitation personnel and some by private providers. Results have are yet to be published.

Congress continues to search for additional incentives for return to work by SS beneficiaries, and this is one of the mandates for the study mentioned earlier. Many argue that with the current definition of disability, the first-pay status and no "job banks" for rehabilitated individuals, most Social Security beneficiaries will never return to work.

There are just too many reasons for beneficiaries to stick with the SS payment rather than risk loosing both the benefit and medical insurance. In addition, many employers are reluctant to hire these persons and maintain that reasonable accommodation would generally bring about undue hardship because of the severity of the impairments or because the majority of Social Security beneficiaries are not qualified for jobs.

Participants and Payors in DM (Insurers, Employers, Employees): Rehabilitation Viewpoints

"For rehabilitation professionals to remain partners in the human resource initiative (DM) requires that we carefully examine the paradigm of our service model in light of public criticisms, and that we understand and incorporate successes innovative employers are realizing in the prevention and management of work injury and disability." (Habeck, ref.13)

"The problem of exactly how rehabilitation service providers should be selected is not so much whether the public program or private providers should fulfill this role --the public program has largely abandoned the field to the private sector - it is how the private provider should be selected....Back of the controversy about selection is the issue of whom the counselor represents." Berkowitz and Berkowitz, 1991 (7).

"LTD benefits are generally provided on the basis of total disability from one regular occupation or from other occupations commensurate with background, experience and residual abilities.... In order to effectively adjudicate these issues....rehabilitation practitioners providing services to LTD claimants must have a working model on which service delivery will also be based." Keppel, 1990 (21). Ms. Keppel suggests a "Real Job Market-Model for LTD Rehabilitation and Claims Adjudication." (Real jobs need to be available)

Carolyn Weaver in her discussion of the need to change the public vocational rehabilitation system by providing vouchers for public-program beneficiaries who could then shop for the right service, makes many important points which have general application. (Ref. no.21) Her major premise is that, "Public agencies and private firms, if competing to attract new customers, would have the incentive to experiment with new diagnostic and evaluation techniques, new methods of case management or placement, as well as new forms of administration and financing as they attempted to supply what customers wanted at a price they were willing to pay." Customers in this case are the actual users of services.

The private rehabilitation provider does have a unique role. The rising costs of rehabilitation services in Workers' Compensation without documentation of significant cost benefit have led to a reversal of mandatory rehabilitation requirements. Employee benefit insurers and employers who self-insure generally espouse the virtues of rehabilitation but also want to see results that spell success in their terms.

Employees may not have the incentive to participate in rehabilitation if their disability status looks better than returning to work in a hostile environment. This is especially if they are long-time workers with the physical problems of aging and frequently unhealthy life styles. When the economic environment results in layoffs and downsizing, a worker with an impairment may feel more secure on disability and may resist any rehabilitation effort.

Employers who are insured may not see any value in bringing a person back to work when the insurer is paying the benefits, unless there is an issue of experience rating and their insurance premiums can be lowered by return to work. Once a replacement employee is hired and working at full pace, rehabilitation may cost more.

Insurers who believe rehabilitation is possible for a given employee may be reluctant to push an employer for fear of loosing a customer, or if the insurance company has sold a policy through a broker and the employer goes to the broker and complains, the insurer may choose not to push the issue in the face of loosing both the employer and the broker as customers.

However, rehabilitation professionals may be able to deflect these negative attitudes and create positive rehabili-

tation results with cost-effective approaches and realistic assessment of the motivations of all parties. However rehabilitation professions must define practice guidelines and be better trained in the dynamics of DM and the interaction of the programs at play in the work place, balanced with their responsibility individual clients.

Responsibilities and rights under the ADA are also important. If an employee with a disability is motivated to work and the employer can make reasonable accommodation, including flexible hours, switches to vacant positions and changes in the physical plant, it is the employee's right and the employer's responsibility to work toward job placement. Rehabilitation can be the linchpin.

Watch for These Change Agents!

The ADA

The ADA is not just another piece of legislation that will quietly be set aside. The National Council on Disability, an independent federal agency charged by Congress to analyze and provide recommendations on issues of public policy for people with disabilities, was instrumental in initiating the ADA. This agency has also established the ADA Watch, an ongoing activity that will report to Congress and the public. Key findings include the following:

> *Complaints filed under the ADA thus far indicate that certain key areas need greater attention, including, for example, accommodating current employees with disabilities.*
>
> *Major elements of employee benefit plans are being called into question by the ADA, such as whether an employer's health care plan may discontinue coverage of certain benefits specifically needed by people with disabilities. (23)*
>
> *According ot EEOC records through May, 21.5% of the charges related to accommodations; back was the highest impairment category.*

The ADA will support most DM objectives and will also move more recalcitrant employers into the fold. "Rehabilitation professionals have more muscle to achieve return to work goals for employees with disabilities who want to return- to-work and that means more success," says Kaye McDevitt, RN,MS,CRC, Regional Director of Disability Management Services.

Health Care Reform

Health care reform can only have positive effects for persons who have not had access to health care. However, there could be some negative ramifications for DM and rehabilitation professionals.

There may be less money from employers to provide for other employee benefits. While employers most who provide non-mandatory disability coverages generally also provide health insurance, others do not. With increased costs of health care, other employee benefits may be dropped or the employer's contribution reduced.

Inclusion of WC in the health-care reform package could revise payments for WC medical care. First dollar coverage may be gone, and that can in turn affect medical-care choices. Moreover, the indemnity WC benefit, which most often encourages or provides rehabilitation services, may drastically change both in terms of who insures the benefit and how it is managed.

There is also concern that more conservative treatment in managed competition could reduce aggressive return to function, return to work efforts of employers and disability insurers. The basic plan may not include this type of treatment. If global budgeting prohibits extra-contractual payment or slows access to treatment, disability incidence and duration can be increased.

Rehabilitation professionals may have a whole new cast of characters with whom to work in case management. The access to records and the very existence of records may change. Funding for rehabilitation if not in the plan must be secured from other sources.

Twenty-Four Hour Coverage

Twenty-four hour coverage has been used mostly in conjunction with discussions of medical benefits. In general it means that no matter how an injury or illness arose, the same "insurance" plan would pay for treatment. To put it another way, medical care (or disability benefits) are provided regardless of whether the illness or injury happened in the course of employment. The employer has a specific financial responsibility for some or all of the costs. As much as we hear about this concept, it is not in effect anywhere at this point. There are still distinct benefits and rules for each medical and disability program.

State law provides for twenty-four hour coverage in Florida but it has not been implemented because of some real sticking points around reduction in coverage now provided under the WC statutes. Other states have taken some action and Texas allows employers to opt out of the WC system but they remain liable for WC injuries. California has introduced legislation for twenty-four hour disability coverage but much debate remains ahead before final passage according to most commentators.

In effect, the health care reform, if it maintains its position on inclusion of WC Medical benefits, puts twenty-four medical coverage in place. Employers must provide medical care benefits for all illness and injury. It is not clear if the first dollar payment status of WC would be maintained. If so, this would increase costs. Also, if WC remains in the health care reform package, there it too would be subject to managed care approaches.

Separating out medical care from the WC indemnity benefit may give more impetus to twenty-four hour disability coverage. Legislation introduced in California includes twenty-four hour disability coverage. (24) Now, non-WC coverage does not generally provide benefits for permanent partial disability - where there is some loss in work function

but the person can return to work. This is the type of benefit that is the most subject to litigation. We can expect a different type of disability management with twenty-four hour coverage. Current WC rehabilitation provisions would no doubt change.

Twenty-four hour coverage can mean that insurers who specialize in the now separate coverages may need to form joint ventures.

Social Security Reform

Disability advocates, disabled persons and tax payors, while united in their drive for Social Security reform, have different perspectives on the issue.

The thrust for Social Security reform seems anchored in providing more support for persons with disabilities to allow them to enter or remain in the work force. The trend is away from strictly cash benefits for total disability toward a combined compensation-and- support-services strategy that enables a person to be productive.

Another reform element is the move away from a strictly medical model in determining disability. Many people who meet the current Social Security medical listings do in fact work. Critics maintain that disability benefits should be based on functional abilities compared to essential functions of jobs. Social Security should then provide financial support in the way of wage supplementation for lower paying jobs or services to increase functional ability, which can in turn have earning capacity.

Rehabilitation professionals would have important roles to play under either reform scenario.

Summary

Public and private insurance trends are built on the need for cost savings related to human resources. There are savings when disability is prevented but also when persons with disabilities can be productive in spite of disability.

DM, founded on saving human and dollar costs related to disability, is becoming more sophisticated. Rehabilitation is an essential element of an integrated DM program in the work place.

Rehabilitation professionals can succeed when they understand DM and the perspectives of the key players: employers, employees and third-party payors, primarily insurers. Rehabilitation professionals must link their activities to cost- saving objectives and learn how to measure and report cost savings.

Profound change is in the wings. The ADA, health care reform, the potential for twenty-four hour disability coverage and revision of the Social Security System are in various stages of development. The ADA is being interpreted by government agencies and courts in relation to actions both taken and not taken. Health care reform is predicted to be an ongoing process over the next few years. Social Security disability policy is being studied and recommendations for change formulated.

(I have not discussed Long Term Care Insurance as it is not currently a major employee benefit nor is the definition tied to inability to work. I do believe however that rehabilitation professionals should watch this area. Long Term Care is tied to activities of daily living. Rehabilitation services to enhance, restore person's abilities to engage in activities of daily living will surely be in greater demand.)

Rehabilitation professionals can help shape changes that occur and certainly the field will be reshaped by the changes.

Epilogue

Dmopoly

I find it intriguing to view DM as Dmopoly, a hypothetical board game where the player's objective is to have money proportionately assigned to each token they are given; there is an ideal balance among tokens, given the money available. The first player to reach the prescribed balance wins. If no one reaches the ideal state, the player who is the closest wins.

The tokens represent an Insurance Company, Employer, Employee, Rehabilitation Providers, Doctors and other health care providers, Ergonomic Design/product firms, etc. Each participant begins with a certain amount of seed money assigned to each token. Players may receive money from a savings pool or contribute to a cost pool determined by movement around a board with spaces representing various disability events or DM activities. Movement is based on the roll of dice. Players may land on squares that permit them to insure all or part of the risk or to reinsure for their insurance token. EAPs can be purchased and Rehabilitation professionals can get money if they are hired and show cost savings, but the employer or insurer has to give up money to hire them. However, cost savings may be taken from the savings pool and allotted to each token, including the employee. There are penalty spaces when for example, supervisors are uninformed on DM policy.

This flight of fancy graphically illustrates the potential complexity of DM. Players must have an overall strategy for all tokens and record their plays. They must continually check that all tokens are moving toward the optimal balance.

REFERENCES

1. *Disability Statistic Abstract*, Number 2, December 1991, Number 4, May 1992, The Institute for Health and Aging, School of Nursing, University of California.
2. *Monthly Labor Review*, Vol.115, No. 12, Table 50, p.106, (December, 1992)
3. Stone, Deborah A., (1979) *The Disabled State*, Temple University Press, 1984.
4. Akabas, Sheila H., Gates, Lauren B., Galvin, Donald E. (1992) *Disability Management*, AMACOM, 1992
5. Schwartz, G.E., S.D.Watson, D.E. Galvin and E. Lipoff(1989) *The Disability Management Sourcebook, 1*. Washington, D.C.: Washington Business Group on Health.

6. Berkowitz, Monroe, (1990) *Journal of Disability Policy Studies, Should Rehabilitation Be Mandatory in Workers' Compensation Programs?*, Volume 1, Number 1, Spring 1990
7. Berkowitz, Monroe and Berkowitz, Edward, (1991) *Rehabilitation Counseling Bulletin, Journal of the American Rehabilitation Counseling Association, Rehabilitation in the Work Injury Program*, Volume 34, Number 3, March 1991.
8. Berkowitz, Edward, (1987) *Disabled Policy, America's Programs for the Handicapped, A Twentieth Century Fund Report*, Cambridge University Press, 1987
9. Burton, John, with Workers Compensation Research Institute (WCRI), (1993) *John Burton's Workers' Compensation Monitor, Cost Drivers in Six States*, Volume 6, Number 1, January/ February, 1993
10. Burton, John, (1993), *John Burton's Workers' Compensation Monitor, Workers' Compensation Costs, 1960-1992: The Increases, The Causes, and The Consequences*, Volume 6, Number 2, March/April, 1993
11. Habeck, Rochelle V.(1991) *National Association of Rehabilitation Professionals in the Private Sector, Managing Disability in Industry*, Volume 6, Number 4, August, 1991.
12. Hunt, H. Allan, Habeck, Rochelle V., (1993) *W.E. Upjohn Institute for Employment Research, The Michigan Disability Prevention Study, Research Highlights*
13. Habeck, Rochelle V. (93) *Achieving Quality and Value in Service to the Workplace Work Injury Management*, Oral presentation, Printing in progress.
14. UNUM Life Insurance Company of America, (1992) *Disability Management: Costs and Solutions, A special UNUM report on the costs, management and prevention of disability*. Available from UNUM, Portland, Ma.
15. Elizabeth Dole and Janet L. Norwood, (1989) *Employee Benefits in Medium and Large Firms*, Bulletin 2363, U.S.Dept of Labor, Bureau of Labor Statistics (Washington, D.C., GPO, June, 1990)
16. Lynn Martin and Janet L. Norwood,(1990) *Employee Benefits in Small Private Establishments*, Bulletin 2388, U.S. Dept. of Labor, Bureau of Labor Statistics (Washington, D.C., GPO, September 1991)
17. Monroe Berkowitz and Carolyn Greene (1989) Disability Expenditures, American Rehabilitation, Volume 15, #1, Spring 1989.
18. James Chelius, Donald Galvin, Patricia Owens (1992) *Disability: It's more expensive than you think, Business and Health*, March 1992, Copyright 1992 and published by Medical Economics Publishing, Montvale, N.J. 07645-1742
19. *The Social Security Disability Insurance Program, An Analysis* (December, 1992) Report of the Department of Health and Human Services pursuant to a request from the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds.
20. Committee on Ways and Means, U.S. House of Representatives, (1992), *The 1992 Green Book, Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, May 15, 1992 (Washington D.C., GPO, 1992)
21. Allison Keppel, (1990) *Issues in Long Term Disability and Risk Analysis, Journal of Private Sector Rehabilitation*, Vol. 5, No.1, 1990.
22. Weaver, Carolyn L. (1991) *Choice in Rehabilitation: A Proposal for Empowering People with Disabilities*, The American Enterprise, July/August, 1991, Vol.2, No. 4.
23. *ADA Watch - Year One: A Report to the President and the Congress on Progress in Implementing the Americans with Disabilities Act*, April 5, 1993, National Council on Disability.
24. Equal Employment Opportunity Commission, *National Data Base Report*, 5/31/93.
25. California Workers' Compensation Institute, (1993), *Framing the Issues: Twenty-Four Hour Coverage, Research Update*

Dr. Owens emphasizes the insurance industry in her analysis of the trends and issues in rehabilitation, and not inappropriately so. The needs of the insurance industry have likely been the foundation for and the major driving force behind the formation of the private sector in rehabilitation. Although it is interesting to have this insight, the more useful question is, what else is out there that may either be equally useful to us in private practice as a referral base, or what may become one in the future?

A broad referral base is essential for any private practitioner as it helps avoid the catastrophe of having it all "go away" on short notice. A broad referral base is likely equally useful for the 'health' of the field in general. Can we, for example, think of ways to generalize our applications in insurance rehabilitation to other settings? What else are private practitioners doing that the field doesn't generally know about? Do we even know who is in private practice in terms of their demographics and professional identities? There are so many unanswered questions that we must have for correctly identifying the broader trends in our field, a knowledge of which is likely essential to our ultimate survival as a unique field in the century to come.

This suggests that in our field we should set the 'trend' of determining how to monitor our own field as well as that of our cohorts, all the better for our own business knowledge and long-range planning. I do not believe this effort is presently in place, and we need it for our own guidance in avoiding becoming too dependent on a sole referral source, even if on the surface it looks as substantial as does the insurance industry. After all, we once thought the same of the savings and loan industry, didn't we?

– Phillip Bussey

Ms.Owens provides an excellent overview of the trends and issues involved in private sector rehabilitation today. In particular, this paper is a very good overview of the various activities involved in private sector rehabilitation including a summary of the various programs of the practicing rehabilitation consultant.

A major area of reform would be in the health care area. One of the most interesting phenomena that has occurred in the last five years in private sector rehabilitation has been the nearly startling growth of the case management association based in Little Rock, Arkansas. To illustrate, their fifth annual conference drew nearly 2,000 practitioners this last year. In addition, the Commission in Chicago has received over five thousand applications for the grandfathering of the certified case management exam. It would seem that the tremendous interest given to this area is directly related to the upcoming reforms in the health care area. In fact, many professionals in the private sector field look to case management as the new big growth area for private sector rehabilitation. In my opinion, this growth has already established itself.

Related to the health care movement, the ADA law and its implications for the future still remain to be enormous. While the response to ADA has been rather sluggish and somewhat immobile, recent court cases as well as those that are pending will serve as a strong stimulus for employers to begin taking seriously the intent of the law under ADA. When employers begin to realize that the ADA means serious business, the potential for private sector consulting will manifest itself rather quickly for rehabilitation consultants and private companies.

In both of these areas, the ADA and case management, there are tremendous needs for training and technical knowledge if the rehabilitation consultant is going to be a reliable resource for both funding sources and employers in the future. It would seem that a tremendous amount of work needs to be accomplished in order to adequately provide competently trained professionals to meet these emerging needs.

– Tim Field

The potential for employment of rehabilitation professionals in workplace disability management has yet to be fully realized by the professional rehabilitation community. The disability management model described by Ms. Owens expands the traditional private sector rehabilitation professional ' s role to include prevention programs which focus on employee wellbeing, health and safety. All too often, the focus is on rehabilitation following disability. In addition, workplace disability management has tended to center on workers' compensation rehabilitation. Ms. Owens reminds us that rehabilitation provisions are common in short-term, long-term and individual disability plans, and the social security disability program.

One particular point made in regard to workers' compensation programs has been expressed in this manuscript as well as in other 1993 Switzer papers. It also relates to other insurance rehabilitation systems. This point focuses on the weakening of formal mandated rehabilitation programs as part of workers' compensation legislation. Without documentation of rehabilitation effectiveness and efficiency in terms of human and dollar costs, workplace disability management will never be realized to its full potential. The public rehabilitation system has been able to document this data for years through program evaluation methods.

The author's discussion of a hypothetical board game, DMopoly, allows the reader to view the complexities surrounding disability management. (This hypothetical board game is similar to the actual board game titled "The Disability Trap" by Valpar International.) Disability manage-

ment should not be a haphazard system but one which has a positive, forward-moving strategy where all of the many parties involved maintain clear, open communication and work in concert with each other for a successful outcome. The complexities of the system need to be minimized so that everyone involved in the process, particularly the worker with a disability, receives appropriate, timely and cost effective services.

A variety of "change agents," which are expected to significantly impact disability management, is presented. These include: the Americans With Disabilities Act, health care reform Twenty-four coverage and social security reform. Since the national state and local environments will see much change in the near future regarding the above issues , rehabilitation professionals must be keenly aware of existing, proposed and new pieces of legislation and policies so that they can accurately predict the trends in disability management and respond accordingly. Rehabilitation professionals have much expertise to offer in these changing times , and must be proactive in dealing with current issues. We cannot afford to sit back and wait for things to happen; we must participate in legislative efforts and policy changes to ensure that rehabilitation is viewed as a worthwhile option in disability management.

– Juliet H. Fried

Owens' paper effectively illustrates the complexity and diversity of insurance issues in disability management. A very important issue is the need for a comprehensive and integrated disability management model. Both in education and practice our society has increasingly moved toward specialization and narrowly focused expertise. Over-specialization, and thick walls between professionals will not work in disability management. An effective disability management model requires professionals from many diverse disciplines and perspectives to work together effectively to meet common goals.

Owens suggests that there is an important role for rehabilitation professionals in disability management. Clearly there is overlap between the mission of vocational rehabilitation and the purpose of disability management. The field of rehabilitation needs to look closely at the type of skills and expertise it can provide to employers and insurers to facilitate reductions in injuries, prompt and effective medical and vocational rehabilitation, and swift return to work.

A second point raised by Owens concerns disincentives to return to work. The importance of secondary gains and systemic disincentives are areas that still require public policy attention, and serious consideration by practitioners.

– Dennis Gilbride

The workplace disability management (DM) model is discussed in length by Ms. Owens. Rehabilitation is emphasized as an integral role in this model with return to work as the ultimate goal. In order for this to be successful, rehabilitation potential and rehabilitation planning must be determined as early as possible.

To control rising cost of disability, regardless of what disability benefit programs, it is obvious that return to work is the absolute goal and early intervention the only acceptable rehabilitation philosophy. Thus is the concept of managed care and 24-hour coverage. Employers will be fully involved with the rehabilitation process of their employees utilizing the resources and skills of a team of health-care providers, rehabilitation practitioners and claims adjusters. As the payor of disability benefits, employers should and will have the actual control of the "cases". This true interdisciplinary approach will be the model of the future. Interestingly, this will also assist employers to comply with the regulation and spirit of the Americans with Disabilities Act (ADA). The actual beneficiaries will be the employees, the individuals with disabilities and society as a whole.

– John W. Lui

The author provides a comprehensive review of the various types of insurance coverage, coverage trends, settlement issues, and a sampling of the disincentives within the current system for successful rehabilitation outcomes. All of these issues are analyzed within a disability management perspective.

In discussing the Social Security system, the author points out that less than lt of the social security population is terminated yearly because of return to work. While I cam aware of the existing disincentives to work, I was truly startled by that very dismal statistic. Clearly, there needs to be much more research into identification of the work disincentives for social security recipients, along with realistic strategies which can assist with moving a greater number of persons with disabilities into the workforce. Hopefully, the studies currently being conducted will provide us with some critical data on how to begin to address the issue of helping people move from dependence to productivity and independence.

Along the lines of social security benefits, the author comments that many employers may be reluctant to hire social security recipients because of either undue hardship or the lack of qualifications on the part of the recipient of benefits. While I do not feel that a blanket statement such as "All persons with disabilities are lacking job qualifications." would be accurate or fair, I think that we in the rehabilitation field need to do a better job in preparing students and young persons with disabilities to be ready and possess skills for the world of work. Rehabilitation counselors working on transition teams, within school districts, and in conjunction with state VR offices can continue to provide services that are essential for the comprehensive education of young persons with disabilities. Offering to employers skilled, motivated workers

who can help the employer to meet their business needs will be the most effective way to reduce or eliminate reluctance to hire based on a stereotypical impression of a specific group of people.

– Patricia Nunez

Ms. Owen's essay is a comprehensive primer on disability management, benefit systems and perspectives which impact private sector rehabilitation. The range of rehabilitation programs described within the scope of disability management are based upon the economic value of an individual employee. Similarly, the existence of disability management programs is based upon their ability to document cost savings to the organization.

Rehabilitation is portrayed as an integral component of disability management programs valued for its ability to reduce benefit expenditures by restoring workers to their pre-injury abilities or other types of work. Statistically supported, Ms. Owens describes an increasing incidence of disability claims, escalating costs and dramatic legislative changes.

Citing the ADA, Health Care Reform, Twenty-four hour coverage and Social Security Reform as four change agents influencing disability management, Ms. Owens identifies an unstable, concentrated and turbulent organizational environment. She correctly states that rehabilitation professional can shape the field and the field of rehabilitation will be shaped by these agents of change.

Perceptive rehabilitation professionals that efficiently observe, analyze and process the changes in their environment will prosper. In a field already recognized for demands of accountability, the documentation of both "hard" and "soft" case management savings appears crucial.

– Stephen A. Zanskas

Seminar Recommendations — Chapter Three

The following is a summary of the recommendations and implications for action as they relate to the discussion of chapter three. These recommendations were developed by an individual work group and the style of presentation reflects their own format along with implications for action.

Service Delivery

The following are implications for service delivery within the private rehabilitation sector. These affect the need for research, training/ education, policy and program development as well as legislation.

1. Recognition of the changing and diverse needs for private rehabilitation services with regard to different insurance product lines.

   The field is going through a significant period of change that will affect the way insurance companies and employers structure and provide disability income products and services. Some of the key forces at work are the Americans with Disabilities Act, healthcare reform, 24-hour coverage, etc.

   As we move through this period of change, the private rehabilitation profession needs to be knowledgeable about the implication these changes will have on the services we deliver. We must be prepared as a profession to evolve to meet the future needs of our customers.

   In addition, we serve a broad range of insurance product lines which have diverse needs. These product lines include Workers' Compensation, short-term disability, long-term disability, individual disability income, personal injury, and liability coverages.

   Across these product lines, there may be similarities in the nature of the services required. However, there are often basic differences such as the expected outcome, funding sources, etc.

   The similarities and differences are not always well understood by the private rehabilitation profession. It also appears there is no clear understanding on the part of insurance companies and employers about how best to utilize private rehabilitation to influence the outcome of cases.

   More needs to be done to stimulate communication and an exchange of information between the insurance industry and private rehabilitation professionals. We need to develop a better understanding of the respective issues which affect both groups. This has implications for joint research and education/training.

2. Timely referral/early intervention.

   Research has repeatedly shown that timely referral and early intervention are keys to successful outcome on cases. However, more needs to be done to educate customers on this fundamental concept and how it can impact the outcome of cases.

3. Professional definition of private rehabilitation services.

   The services provided by private rehabilitation professionals often blur with services provided by other professional specialties. Private rehabilitation needs to develop a clear statement of the range of services that are within the scope of our professional expertise.

4. Resolution of the customer/client debate.

   Private rehabilitation needs to define, understand and resolve the issues surrounding obligations to the customer versus the obligations to the client (consumer) Private rehabilitation needs to develop clearer guidelines regarding the private rehabilitation providers responsibility to each party involved.

Policy or Program Development

1. We recommend certification bodies require a specified amount of continuing education units regarding insurance industry education such as outcome measures, performance expectations, and the disability management spectrum.

2. Develop a workshop or focus group at the National Disability Management Conference which will be held in Washington, DC in the Fall of 1993. Topics to include in the workshop are as follows:

   - disability management model
   - expected outcomes
   - performance delivery expectations

   The structure of the workshop would be interactive including private rehabilitation providers who can share information about the services we provide, outcomes and service specifications such as early intervention and time required on cases to provide specific services.

3. Develop an Adjustors Guide to private rehabilitation services for adjustors within the Workers' Compensation industry.

4. We need to generate more ongoing contact and interaction with insurance companies. We recommend that the Switzer Scholars initiate action on this and encourage NASPPR to assume ongoing responsibility.

5. We request that the National Rehabilitation Association (NRA) approach the Social Security Administration regarding the release of the results of the Demonstration Projects utilizing private rehabili-

tation sector for rehabilitation of Social Security claimants.

Training of Staff/General Public

1. Develop additional training and education for customers (the insurance industry and employers) regarding private rehabilitation services. This would include:
   - more information regarding the services we provide
   - when and how to utilize private rehabilitation services to effect outcome of cases
   - benefits of early intervention/timely referral
   - referral information we need from the customer in order to provide services
2. Develop more education and training for private rehabilitation providers regarding the insurance industry. This would include:
   - expected outcomes
   - performance requirements
   - legal issues affecting and regulating the insurance industry
3. We recommend CORE incorporate more principles of private rehabilitation in graduate levels of rehabilitation counselor education.
4. We need to disseminate more information on private rehabilitation and rehabilitation in general to the general public.

Research

1. There is a need for joint research between the private rehabilitation profession and the insurance industry. The research needs to focus on ideal outcomes, performance standards and measurements, and the evolving disability management model. The design of the research to some extent will depend upon the disability income product line being addressed.

   Organizations to include in consideration of joint research are as follows:
   - California Workers' Compensation Research Institute
   - International Association of Industrial Accident Boards and Commissions
   - National Counsel on Compensation Insurance
   - Workers' Compensation Research Institute
   - American Association of State Compensation Insurance Funds - Insurance Rehabilitation Study Group
2. We need additional research on how to effectively educate the front line adjustor within the Workers' Compensation industry (and other product lines).
3. We recommend an interchange of information between insurance companies in the private rehabilitation profession regarding research that has already been completed. We feel the National Rehabilitation Association needs to be proactive in requesting research information and disseminating it to professional members.
4. We need additional research to identify the outcomes of private rehabilitation. This would include:
   - methods of outcome measurements
   - cost benefit analysis
   - service delivery methodology
   - NIDRR (in the U.S. Dept. of Education) should be approached regarding availability for funding of this type of research.
5. Develop a model for cost-benefit analysis for the different product lines including workers' compensation, long-term disability, etc.
6. Update the study of the comparative analysis of outcomes of public and private sector rehabilitation done by Berkley Planning Associates.

Legislation

1. As we address the healthcare reform issue, assure that rehabilitation professionals are included as reimbursed service providers as a part of the healthcare reform plan.
2. Individual rehabilitation professionals need to lobby on the state level for legislation effecting disability/health policy.
3. We need additional legislation in regard to the Social Security Disability Insurance program for additional incentive to return to work, including time limited benefits with rehabilitation per the recommendation of the Pain Commission.
4. Have input into the National Academy of Social Insurance study of disability policy.

Other

1. Private rehabilitation professionals need to take personal responsibility to develop and disseminate professional information and education.
2. We need to test methods to increase public awareness of rehabilitation and should seek partners within other professional organizations to assist in this process.
3. As Switzer Scholars, we need to be sure the Switzer Monograph is distributed to our customer set to increase knowledge and awareness of private rehabilitation issues.
4. Private rehabilitation professionals need to be proactive with change to evolve our profession accordingly.
5. Develop a long range plan for private rehabilitation and develop leadership to implement that plan within the National Rehabilitation Association and NASPPR.

Chapter Four

Trends & Innovations In Private Sector Rehabilitation For The 21st Century

John W. Lui

For over two decades, private sector rehabilitation has experienced tremendous growth. Increased numbers of experienced public sector rehabilitation counselors have switched to the private sector. Many graduates from both the undergraduate and graduate level programs in rehabilitation counseling or related fields have gone directly into the private sector. This was due to various reasons: the unmet service needs of industrially injured workers by most state rehabilitation systems; the mandatory rehabilitation statues in state worker compensation laws; the perceived intrinsic factors in the job itself such as basic salary incentives, caseload, training opportunities and professional esteem (Howell, 1983). During this time, private sector rehabilitation evolved and matured.

While most counselors are still engaged in providing services in the disability benefit systems such as workers' compensation, long-term disability, social security, etc., others are expanding into the medical institution/systems, the legal system, business and industries, and have even begun to service public/governmental agencies. In the 1990s, due to some major legislation and social movements, crisis in the health-care and state workers' compensation systems, crisis within financial institutions including both the banking and insurance industries, and the poor national economic conditions, private rehabilitation is again at another crossroad. The effect of these many factors will be felt by the entire field of rehabilitation and especially private sector rehabilitation deep into the 21st century.

The Americans with Disabilities Act (ADA), the landmark civil rights bill of 1990 was hailed by people with disabilities as well as the rehabilitation community. Rehabilitation counselors, the supposed experts in working with people with disabilities, are suddenly gurus in addressing different Titles in the ADA. Their skills in job analysis, job development, and job placement, and experiences in the disability field give them great access to one particular group that is severely affected by this law and is eagerly seeking assistance - the employers of the business and industry. The need of a well-written job description identifying essential and marginal functions will greatly enhance the employers' compliance to the employment section of the law. Their knowledge base in job modification will also assist the employers, the employees and job applicants in the area of reasonable accommodation. With special training in accessibility, they are also the consultants in dealing with architectural barriers. They will also be involved as expert witnesses on either the plaintiff or defense side in the case of lawsuits derived from non-compliance with this law. Since ADA is a civil rights bill that will continue to be tested and updated, private rehabilitation will remain active with its existence.

Also effective in 1990 was the Individuals With Disabilities Education Act (IDEA) otherwise known as Public Law 101-476. The whole issue of "transition from school to work" emphasized career oriented, vocational enriched and community integrated experience for students. This translates to ample opportunities for practitioners in private sector rehabilitation in the areas of vocational evaluation, vocational counseling, job placement services, supported employment services, and independent and community living services. Already springing up in the market place are private employment agencies operated by rehabilitation counselors specializing in the placement of individuals with disabilities including students. With the nation's focus on education, school systems may also prove to be the new employment setting that attracts rehabilitation professionals from the private sector. Nonetheless, IDEA will continue to create attractive referral and funding sources for private rehabilitation.

John W. Lui, CAGS, CRC, CIRS, President, Rehabilitation Consultants, Inc., Bedford, New Hampshire.

The Rehabilitation Act was re-authorized and amended in 1992. The common philosophy it shared with ADA and IDEA was choice and empowerment for individuals with disabilities. One of the tools that will enable such a concept is assistive technology. While ADA does not specifically mention assistive technology, "reasonable accommodation" and "accessibility" will require the use of such. The Rehabilitation Act Amendments and IDEA certainly have specific wordings on this issue. Both of these two public laws had actually mandated the use of technology many years ago. But it was not until the passage of Public Law 100-407, The Technology-Related Assistance for Individuals with Disabilities Act of 1988, that the federal government echoed its recognition that all people with disabilities can benefit from technology (Langton, 1991). The inception of ADA suddenly makes "assistive technology" household words amongst practitioners who are involved with the employment process of individuals with disabilities. Their skills and interest in this area will continue to grow as they begin to learn and accept that besides the placement phase where technologies are commonly considered, that there are other places in the rehabilitation process where consideration of the use of technology or technology related services should take place (Langton, 1991). This whole area of assistive technology will have an impact on the private rehabilitation practitioners in their day to day work, will bring other professionals into the arena of private rehabilitation such as occupational therapists, physical therapists and rehabilitation engineers, will create new career opportunities for some practitioners with special skill sets and interests, and will create demand in new market areas.

As we approach the new century, we must face up to one of the most obvious but often overlooked domestic issues in the United States: "the abilities of communities to work and live together more productively with all types and groups of People" (Wehman, 1993). In 1990, almost one in four Americans had African, Asian, Hispanic, or American Indian ancestry, in contrast to one in five in 1980 (Leung, 1993). A society of multi-ethnicity is here and is here to stay. Private rehabilitation practitioners will encounter greater diversity in the clients they serve and in the workplace that they are employed. Since these providers practice in a wide array of employment settings and systems, their likelihood in meeting clients of other cultures is no doubt very high. This lack of knowledge about cultures other than their own will create unintentional roadblocks to provide specific services or to successfully complete the rehabilitation process (Watson and Eilenberg, 1993). While there exists little information in rehabilitation literature in minority ethnic population utilization of human service delivery programs, these studies were confined specifically in the state/federal vocational rehabilitation systems. There is definitely a scarcity of research on the same topic in private rehabilitation. This huge vacuum of information will severely compound the difficulties private rehabilitation practitioners must face to address the issue of diversity.

It was obvious that one of President Bill Clinton's goal after he takes office is to overhaul the health-care system. The intent is to expand the system to include the 37 million Americans who have no health insurance and the roughly 35 million with substandard insurance, and to ultimately control the cost of health care for all Americans (Newsweek, 1993). In addition, it is estimated that 15% of Americans will reach 65 or older by year 2000 (National Geographic, 1993), which will mean increased need for medical and related services. Together with our national focus on AIDS and HIV+ and a resurgence of polio and tuberculosis, the momentum is towards some kind of reform. The shape, form, and funding of this program of universal health coverage has yet to be unveiled by the administration. But some local governments such as Massachusetts, Oregon, Minnesota, Maryland, and Hawaii are already experimenting with their own health-care reform policy. Private rehabilitation practitioners working in the health-care or related programs such as those of medical rehabilitation, mental health, psychological rehabilitation, geriatric and viral infectious diseases will see a major impact and great opportunities.

In connection with health reform, workers' compensation is also experiencing many changes all over this country. Workers' compensation insurance is regarded as one of the most critical problems faced by business and industry. Between 1980 and 1991, employers' premiums for workers' compensation insurance have increased by close to 300 percent, from $22.3 billion to 'an estimate of $62 billion. In 1990, about 25 percent of all employers were unable to obtain mandatory workers' compensation insurance coverage in the voluntary market, as compared to 5.5 percent in 1984. This forced the employers to seek coverage from their state's assigned-risk pool resulting in considerably higher premiums with little claims service. In some states such as Maine and Rhode Island, the percentages of employers in the assigned-risk pool were as high as 80% and 87% respectively (Thompson, 1992). While there are many contributing factors creating this crisis, there are as many disability management strategies employed by business and industry to tackle the problem. The two broad but interrelated topical areas are managed care and legislative reform (Hale, 1992).

The managed care concept, such as Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO), has been used in the health-care system for many years with a very good success record. It is not until recent years that managed care techniques are being recognized as a viable alternative to the workers' compensation system (Brain, 1992). This true team approach has one main objective: "coordination of medical care to maximize a rapid return to work and prevent the development of long-term disability" (Brain, 1992). This disability management strategy will immensely alter the traditional role of each medical and rehabilitation professional, and totally change the delivery of medical and vocational rehabilitation services typically provided to industrially injured workers.

We shall witness an increase in the entry of other professionals especially nurses, vocational evaluators, occupa-

tional therapists and physical therapists in private rehabilitation. The terms "case management" and "case manager" will be redefined. While Certified Rehabilitation Counselor (CRC) and Certified Insurance Rehabilitation Specialist (CIRS) are still the necessary credentials, Certified Case Manager (CCM) will attract the most attention and become the preferred qualification to work in a workers' compensation managed care program. From a business standpoint, this will modify private rehabilitation practitioners' usual customer base and maybe even their financial picture. The entrepreneurial types will explore or establish joint ventures with others to develop their own PPO, and maybe their own managed care programs. There will be new computerized programs that will perform all functions necessary in a workers' compensation managed care program to include no less than: utilization review, bill auditing, loss time analysis, lost work days analysis, PPO database, employer data base, light duty/job modification, job analysis, etc. Laptop computers will be an essential worktool for all practitioners so that they can input, retrieve and update information on their cases instantly.

The other strategy in tackling the workers' compensation crisis lies in the hands of lawmakers. Bombarded by complaints from employers on the astronomical cost of workers' compensation on one side and insurance industry's concern over rate inadequacy, legislators have but one of two choices: major rate hikes or major reforms (Thompson, 1992). It is obvious which direction they will take, especially in consideration of the current economic climate. A sample of some states that introduced workers' compensation reform packages in the last three years includes: Colorado, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, Oregon, Pennsylvania, Rhode Island, and Texas. Reforms ranged from total overhaul, rejection and reduction of proposed rate increase, premium reduction, medical-cost management, legal cost containment, deductibles and mandatory managed care program. These sweeping changes, especially when dictated by law, will affect the entire industry of private rehabilitation in those particular states almost instantly.

For many years, and still true for some states' workers' compensation law, there are no specific qualification requirements for practitioners to provide vocational rehabilitation services to the industrially injured workers. While National Rehabilitation Counseling Association (NRCA) is experiencing the "licensing" movement through out the country (Professional Report, 1992), private rehabilitation is also facing credentialing and licensing legislation in the workers' compensation system. This is certainly inevitable as private rehabilitation as a profession matures and thus the need to protect and upgrade this vocation. At the same time, it is just as important that the injured workers should receive quality care and be protected from impostors and unethical practices. This trend will most positively continue and may coincide with some of the states' proposed reforms.

As mentioned in the beginning of this article, public laws in recent years will no doubt leave their footprints beyond the 21st century. ADA will continue to provide many opportunities for the practitioners who possess the appropriate skills. To safeguard the citizens and businesses, it is foreseeable that there will be state regulations " certifying" individuals to become "ADA Experts". The Commonwealth of Massachusetts already has such a statue. As there are more test cases challenging this law, so will the private practitioners' ethics and skills.

Due to IDEA and the Rehabilitation Act Amendments, private rehabilitation may experience attrition of its professionals to school systems, the state units of Division of Vocational Rehabilitation or other community rehabilitation programs. At the same time, there is a movement in recent years towards "public-private partnership." This is evident in both federal and state programs such as Veterans Administration, Division of Vocational

Rehabilitation, Social Security Administration, and Job Training Partnership Act, etc. As the rehabilitation dollar shrinks in the workers' compensation system due to poor economy and legislative reforms, more and more private rehabilitation firms and practitioners may shift to these sources to compensate for revenue loss.

The arrival of these three public laws will assure that assistive technology will continue to be the growing field both in the public and private sector rehabilitation. Knowledge in the application of assistive technology in the rehabilitation process will help to address the issues of "choice and empowerment" and success" and successful outcome for the individuals with disabilities. Private rehabilitation practitioners must acquire a basic understanding of what assistive technology is and what can realistically be expected from its use (Langton, 1993). They must learn to work with specialized technology service providers and other professionals to form a "technology team" to identify possible solutions to functional needs. An organization such as RESNA that is "an interdisciplinary association for the advancement of rehabilitation and assistive technology" may be an excellent resource.

As the population of the United States continues to change, private rehabilitation practitioners must be ready to face these challenges if they are expected to be effective. While there is a strong need of research in the entire field of private rehabilitation, there is an urgency of doing research on the area of multi-ethnicity and the rehabilitation process in disability benefit systems and medical rehabilitation systems. Training and education in dealing with clients, and co-workers with different backgrounds will help practitioners become more aware of their own personal and professional biases and more sensitive to other culture's way in dealing with issues of disability adjustment, language barrier, expressing and verbalizing emotions and help seeking behavior (Chan, Lam, Wong, Leung and Fang, 1988; Leung, 1993).

There is no doubt that health-care reform is on the horizon. There is also prediction that President Clinton will include workers' compensation medical benefits in the national health-care reform package (Thompson, 1993). If the managed care concept prevails, it will mean major changes and opportunities for private rehabilitation practitioners.

24-hour medical coverage and team approach in managing health-care patients or industrially injured workers will be the norm. Besides the employers and the employees , practitioners must develop a favorable working relationship with the other professionals in the network to become effective. National Association of Service Providers in Private Rehabilitation (NASPPR), the recently formed division of National Rehabilitation Association (NRA), with its charter to include "all others interested in the rehabilitation process" will provide a great forum to share ideas, to foster synergy and to effect legislation collectively.

As we approach the 21st Century, one thing is sure: private rehabilitation as a field has matured. It has gone from a totally unregulated industry two decades ago to become one of full regulation. Its practitioners have diversified to include professionals in many disciplines to address the entire process of rehabilitation and client care. Licensing will be in place to insure the necessary qualifications and skills to practice thus establishing a level of professional competence and esteem. The organization of a professional association nationwide further indicates the stability and staying power of this field. Private rehabilitation cannot be in a better position to meet the challenges in 2001 and beyond.

References

Brain, Gail F. (1992). Managed care programs. *Occupational Disorders of the Upper Extremity*, 89-99. New York, NY: Churchill Livingston.

Chan, Fong., Lam, Chow S., Wong, Daniel., Leung Paul & Fang, Xue-Shen. (1988, Winter). Counseling Chinese Americans with disabilities. *Journal of Applied Rehabilitation Counseling, 19*(4), 21-25.

Hale, Jeffrey E. (1992). *"Disability management in workers' compensation: A survey of current practice and demand among New Hampshire employers"*. Prepared to meet requirement for a Masters Degree in Business Administration at Plymouth State College, Plymouth, NH.

Howell, Joanne C. (1983) Differences between public and private rehabilitation services and the professionals who staff them. *Journal of Applied Rehabilitation Counseling, 14*(2), 17-22.

Langton, Anthony J. (1991, July). Utilizing Technology in the vocational rehabilitation process. *Issues & Applications in Assistive Technology.*

Langton, Anthony J. (1993, Spring). Making more effective use of assistive technology in the vocational evaluation process. *Vocational Evaluation and Work Adjustment Bulletin, 26*(1), 13-19.

Leung, Paul. (1993) A changing demography and its challenge. *Journal of Vocational Rehabilitation, 3*(1), 3-11.

Morganthau, Tom., Hager, Mary., Thomas, Rich., & Clift, Eleanor. (1993, May 17). Down to brass tacks. *Newsweek*, 36-37.

Riley, Scott Lynn. (1993, June). Okinawa: A terrific place to grow old. *National Geographic*, Geographica.

Tarvydas, Vilia. (1992, May/June). Rehabilitation counselors active in licensure. *Professional Report of the National Rehabilitation Counseling Association*, Vol. 33,1-2.

Thompson, Roger. (1992, July). Workers' comp costs: Out of control. *Nation's Business*, 22-30.

Thompson, Roger. (1993, May). Health reform aims at workers' comp. *Nation's Business*, 34-36.

Watson, Albert L. & Eilenberg, Laurie. (1993, Spring) The multicultural counselor. *CRC: The Counselor*, 2-4.

Wehman, Paul. (1993) From the Editor. *Journal of Vocational Rehabilitation, 3*(1), 1.

Mr. Lui's paper focuses on key changes in legislation, the work place, and the structure of compensation systems which will create a new playing field for a private sector rehabilitation for the future. We are at a threshold of change that will affect service delivery for the year 2000 and beyond.

Some of the implications for change are as follows:

1. Rehabilitation education appears to be geared to produce professionals for the public sector. We need to ensure that we have a supply of qualified professionals for the private sector and need to address the funding of rehabilitation education and curriculum to achieve this.

2. Rehabilitation counselors will need to be better prepared to deal modification and field accommodation in the work place. There will need to be additional emphasis inrehabilitation counselor education.

3. The trend to global business expansion may create issues of rehabilitation service delivery on an international basis for those companies who have expanded beyond United States' borders.

4. We will see increasing diversity in the work force.One issue for rehabilitation will be the increasing need for bilingual or multilingual counselors. The aging work force will also create additional challenges in terms of the range to nature of disabilities.

5. A significant barrier to employment for individuals with disabilities may be removed as a result of health care reform. The increased access to health care needs to be coupled with legislative changes for incentives within the Social Security compensation system to stimulate and facilitate return to work.

– Catherine C. Bennett

I believe Dr. Lui has touched on to some of the major issues of relevance to our field in the years to come, such as the Americans with Disabilities Act, a federal law that may be revised but likely will never go away. He also draws our attention to the more instantly important issue of many other professions calling themselves rehabilitation practitioners, many of whom have no training or experience of consequence in our field.

He therefore brings us to the most important question of all, will we survive as a profession at all in the 21st century? The federal government is in a phase of cutting back spending by passing along federally mandated programs to be provided solely or mostly by state funding. In Maryland we can already see its impact in the provision of community-based mental health services, which are being phased out as the state in turn passes the obligation along to individual counties which can not afford to provide them. Public sector rehabilitation can not help but be affected by a trend of this type. Private sector rehabilitation is no less vulnerable in its own way.

Our first task in planning for the 21st century should be to find out if we are at risk for even surviving, and if so, to what degree. Our planning, education, service delivery, and all the other elements that comprise what we presently think of as rehabilitation counseling as a profession will have to take these findings into consideration, but hopefully in a proactive and coordinated fashion in ways that will be new to us all.

We are the beneficiaries of the work of the giants of our field, like Mary Switzer, persons who did not wait for events to overtake them. Rather, they worked to shape the events for the benefit of rehabilitation. That is our challenge, and one which I believe we must meet to assure our survival in the years to come.

– Phillip Bussey

Rehabilitation in the private sector has indeed experienced enormous growth and expansion since its inception in the late 1960's. The foundation for such a movement has clearly found its roots in the state federal programs that had been in place for nearly seventy years. New funding sources, primarily the insurance companies for compensation programs, have required rehabilitation professionals to deliver services in new and innovative ways for returning the injured worker to jobs.

In his paper, Mr. Lui has identified some new programs that will further redirect the private sector movement in the next decade. Namely, the ADA, Public Law 101-476, and public law 100-407 will clearly identify new trends and required innovations for service delivery. In particular, the ADA will redefine the role of the private sector rehabilitation practitioner as litigation identifies the critical issues in the hiring and employment process as well as fueling a greater interest for resolutions in behalf of persons with disabilities. There indeed will be a greater diversity of clients and programs responding to client needs which in turn will require a varied responses on part of the practitioner.

One of the major shifts that will be required, in my opinion, is the source of training for rehabilitation professionals in both the public and private sectors. The once staid university programs that have been funded by the RSA for the last forty years will need a thorough reevaluation and reassessment with respect to the emerging needs of the professional in areas of service delivery. As new laws are enacted, at both the federal and state

levels, one can not assume that our current training programs will always be adequate for the practice of professionals in these new areas. Reliance upon the professional associations to meet these needs will not suffice. The university programs must be implicitly involved from the inception and be able to respond to all professionals in the rehabilitation movement.

– Tim Field

The strength of Mr. Lui's manuscript lies in its comprehensiveness and enthusiastic discussion of trends and innovations in private sector rehabilitation for the next century. As is evidenced throughout the text, numerous opportunities exist for the future of private for-profit rehabilitation professionals. The only thing preventing continued growth in the field is the lack of an entrepreneurial spirit to address these trends and forecast others. The future of rehabilitation depends upon not only our ability to forecast trends but also to actively develop services which are consistent with these tendencies. Mr. Lui presents a wide range of excellent ideas and opportunities which utilizes the expertise of private sector rehabilitation professionals. Individuals and companies must take advantage of current and future opportunities.

One area highlighted in this manuscript was that of assistive technology. With the Technology-Related Assistance for Individuals with Disabilities Act, the Americans with Disabilities Act, the Rehabilitation Act Amendments and other legislation, knowledge of assistive technology will be necessary for practitioners in both the public and private sectors. However, opportunities exist for many private for-profit rehabilitation professionals to develop special skills and expertise in this growing area and find themselves in great demand when it comes to issues of reasonable accommodation and accessibility. Although many rehabilitation counselors see assistive technology as a service to be purchased from other related professionals, this area has great promise for all of those rehabilitation professionals willing to expand their typical roles and skills.

Another area highlighted in this manuscript was that of multi-culturalism. Private rehabilitation professionals will not only need to be sensitive to and possess some knowledge about various cultures, they may also find an opportunity to specialize in specific cultures by developing a significant amount of knowledge and expertise in working with individuals from these populations.

Mr. Lui should be commended for his recognition of rehabilitation professionals, other than counselors, who are and will be involved in addressing the entire process of rehabilitation and client care within the private sector. It is important to recognize that a wide array of rehabilitation related professionals are among those working independently, as well as with teams, in the coordination and provision of client services. This is evidenced in the various types of national rehabilitation certifications including : Certified Vocational Evaluator, Certified Rehabilitation Counselor, Certified Insurance Rehabilitation Specialist, Certified Rehabilitation Registered Nurse and the recently created Certified Case Manager, to name a few. In recognizing this diversity of rehabilitation professionals and the various certifications they possess, it is also important to indicate that this may be the basis of many problems encountered in the private sector regarding turf and ethical issues. There are ways, however, of dealing with such issues by bringing people together from various disciplines to discuss commonalities and differences, and communicate this information to the various professional groups they represent.

– Juliet H. Fried

Lui identifies a number of important factors that will impact on the future provision of rehabilitation. Health care reform will obviously have tremendous impact. However, at this early date it is not clear how health care will change as a result of reform, nor is it clear that vocational rehabilitation has presented a thoughtful policy on its role in a comprehensive plan.

Lui points out the obvious opportunities that rehabilitation providers would seem to have in assisting employers in implementing title one of the ADA. However, the limited data available suggests that at present rehabilitation is not playing as central a role as many assumed it would.

The impact of the technology revolution and the changes it will bring to the world of work can't be emphasized enough. Advances in assistive technology and new types of information processing jobs will provide opportunities for people with even the most severe disabilities undreamed of a decade ago.

Lui discussed the entry of other professionals into private rehabilitation. He noted how central case management has become to the entire process and he mentioned the new certification as a case manager (CCM). This whole topic raises questions concerning what private rehabilitation is, what training best prepares people for work in this field, and the relationship between rehabilitation counselors, rehabilitation nurses, and other allied health professionals.

– Dennis Gilbride

The author has allowed us a brief glimpse into the next century, and it is clear that private sector rehabilitation as we know it will be undergoing some major shifts and changes in the years to come. Two specific areas I would like to comment on are diversity and regulating ADA services.

The author recognizes that there has been some research in the area of minority ethnic populations and their interfacing with the state/federal rehabilitation systems. However, when one considers the age of the state/federal system, the brief amount of literature devoted to multicultural issues is indeed shocking. Therefore, it is not surprising that in the (relatively) new field of private rehabilitation, issues

of cultural diversity have not begun to be adequately addressed. It is undeniable that the more information a rehabilitation counselor knows about a client's background, values and family/community support systems, the greater the likelihood of that counselor working effectively with the client. Clearly this is an area that is wide open for future research, and we need to begin to incorporate multicultural training into inservice and professional seminars targeting private rehabilitation practitioners. Obtaining information about a clients' culture should become as automatic as researching an unfamiliar drug, or an unusual diagnosis.

The Americans with Disabilities Act has indeed opened many doors for persons with disabilities. It also, in my opinion, has the potential to become a tremendous "money-maker" for just about anyone who wants to market themselves as "expert" in the area of ADA. The potential for misinformation to be given to employers or others relative to the law will only serve to embitter and alienate employers who are already somewhat anxious about this whole business, to say the least! Regulation of these "experts", as mentioned by the author, can not only serve to protect the consumer of the expert's services, but also will ultimately result in a favorable outcome for persons with disabilities.

– Patricia Nunez

Mr. Lui's article characterizes private sector rehabilitation as experiencing tremendous growth and maturation over the past two decades. He suggests this growth is evidenced in the ever expanding employment opportunities available to individuals in private sector rehabilitation. However, as the field has matured, Mr. Lui perceptively identifies sweeping social and legislative movements, crises in worker's compensation and health care as well as a stagnant economy which he predicts will influence rehabilitation well into the 21st century.

The Americans with Disability Act (ADA), the Individuals with Disabilities Education Act (IDEA), reauthorization of the Rehabilitation Act and Technology-Related Assistance for Individuals with Disabilities Act were passed between 1988 and 1992. These laws have layed the foundation for choice and empowerment for individuals with disabilities. The implementation of civil rights law, transition from school to work and assistive technology represent new markets for private sector rehabilitation professionals.

A number of other factors are precursors to change. Demographically, our population is aging and increasingly ethnically diverse. Rapidly escalating worker's compensation and health care costs along with an estimated 72 million uninsured or underinsured Americans predict health care reform. An influx of other allied health professionals into private rehabilitation markets will continue to drive the demand for certifications.

Mr. Lui's paper reflects a dynamic, turbulent work environment. Optimistic in his appraisal of rehabilitation's position to address the future challenges, his article suggests a number of opportunities for future research and entrepreneurial, market responsive, private sector rehabilitation professionals.

– Stephen A. Zanskas

The following is a summary of the recommendations and implications for action as they relate to the discussion of chapter Four. These recommendations were developed by an individual work group and the style of presentation reflects their own format along with implications for action.

Program or Policy Development

1. A National body to advocate for legislative change in worker's compensation.

A body to monitor changes in the environment that will have long-term impact on rehabilitation, i.e. the new health care plan. ADA.Purpose is for advocating the inclusion and recognition of rehabilitation counselors and professionals in legislation.

3. Clearinghouse/analysis of actions, decisions, evaluations related to legislative changes for the purpose of relating it to rehabilitation practice.

4. Develop position papers such as "The Role of Workers' Compensation in the Universal Access Debate", and "The Role of the Rehabilitation Counselor in the Universal Access Debate".

Training

1. Insist on comprehensive knowledge of important pieces of legislation such as ADA -- which may be amended, but will not likely go away in our lifetime.

2. Include new skills in continuing education training, such as medication, process consultation which will help rehabilitation counselors train those outside our profession.

3. Encourage private companies to do low pay and no pay internships, maybe use "In memory of" grants for funding.

4. Offer a clearinghouse of trainers to provide programs in rehabilitation topics to non-rehabilitation professionals, i.e. employers, physicians, claims people, the general public.

5. Educate practitioners on the value of public relations.

6. Encourage consumer involvement in training.

Research

1. Support research in rehabilitation by:

   a. Granting sabbaticals for time to do needed research, and

   b. Pay for it through shared contributions form companies, school, Grants

   c.Co-ordinate rehabilitation research with other relevant research.

   d. Offer technical help in skills such as writing.

   e. Use rehabilitation education students for support help.

   f. Encourage professional associations to help in training for writing, research, fund raising activities, etc.

2. Solicit industry support for research, e.g. shared data from companies for projects, evaluating existing data.

3. Cooperative State Agency/Private sector research projects such as service delivery.

4. Help students identify non-government sources of money for support for research.

Other

1. Publicity -- what is a Rehabilitation Counselor, what do they do?

2. Get the category of Rehabilitation Counselor back on the Strong-Campbell Scale. (Interest Scale)

3. Opt for more articles on Rehabilitation Counselors in career literature.

Chapter Five

Ethical Issues In The Private Sector

Edward P. Steffan

Mr. Steffan has addressed probably the most difficult area and collection of issues in all of rehabilitation. Every association or group that comes along tends to develop, and usually does, an ethics standard statement for their organization and group of members. At this day we have approximately twenty different ethics standard statements by the various rehabilitation counseling associations and allied groups that would have some direct or indirect bearing on the practice of rehabilitation consultants.

As Mr. Steffan has correctly observed, the central issue for private sector rehabilitation is and always has been "Who is the client?"

– Tim Field

Ethics is defined by The Oxford American Dictionary as "moral philosophy." Moral is defined as: 1) of or concerned with the goodness and badness of human character, or with the principals of what is right and wrong in conduct, 2) virtuous, 3) capable of understanding and living by the rules of morality.

These definitions will give shape to our discussion on this complex issue. Ethics, or the lack of ethics, have a profound effect upon the service delivery system which currently provides overriding direction to which individuals and what type of rehabilitation services are provided. Given my experience is in the workers' compensation case management system, the examples I will sight related to ethical quandaries will be from personal cases, or have been related to me by other rehabilitation counselors.

It is difficult to discuss ethics without using negative examples to produce insight. That being the case, I must be careful to qualify that it is my belief that a major percentage of people providing medical, counseling, therapy, insurance claims, rehabilitation and related services, try to work ethically within the system in which they practice. I did not describe the negative information in case examples, to infer that other professionals, or we as rehabilitation counselors, individually or as a group, are unethical.

I cannot state strongly enough that I am not sighting examples for any purpose other than to utilize information which I believe to be true to promote growth and insight in ethics.

A continued ethical complaint levied against rehabilitation counselors working in medical management and vocational services involving insurance claims is that the client *is* the insurance company or defense attorneys as opposed to the individual. This ethical concern will permeate the examples utilized for our discussion.

Ethical dilemmas would appear to be a direct consequence of the current practices in most jurisdictions which create an adversarial system. This directly effects ethics because of the perception that a practitioner must choose "a side" for which to specialize. Once having chosen, the rehabilitation counselor must then

Edward P. Steffan, E.P.S. Rehabilitation, Inc., Tinley Park, Illinois

manipulate information to promote the cause or orientation for which one has engaged. This often eliminates the rehabilitation counselor's ability to objectively assess information and develop an objective rehabilitation plan.

Rehabilitation counselors who fight to maintain neutrality may be perceived in the industry as limiting their potential for business growth. Although it appears these rehabilitation companies have a percentage of the available work, it is not the lion's share. It is difficult to assess whether a rehabilitation counselor's willingness to "package" the rehabilitation variables to satisfy a pre-determined outcome or goal, is a cause or effect of the current orientation and ethical dilemmas permeating our industry. By this, I am questioning whether rehabilitation counselors have to choose a side and fortify that position, or because rehabilitation counselors are available to do so since their services are purchased.

Labor Market Surveys have the potential to be misused and misrepresented depending on the difference between the stated purpose, the real purpose, and the motivation of the individual producing the Labor Market Survey. As in all private sector rehabilitation issues, depending on the law governing practice, service providers expertise, and the market-driven motivation of services, the individuals performing Labor Market Surveys can be effected. This effect will be on the quality, content and orientation of Labor Market Surveys, and may pre-determine the outcome.

The following example outlines how a Labor Market Survey, can be utilized for a specific purpose in a misdirected attempt to support a pre-determined position. How the information is utilized, and the process in which it was produced, raises ethical concerns related to who is the client, and what are ethical rehabilitation processes and services?

A forty-four year old foreign born registered nurse, with below average English speaking ability, recovers from a low back injury, with a thirty pound lifting capacity. Experience includes emergency room, orthopedic, and psychiatric nursing. Subsequent to reaching maximum medical recovery, the hospital, as employer, states no positions are available given current rehabilitation variables. The insurance carrier, who owns a captive rehabilitation company, terminated temporary total disability benefits indicating given medical stability, and the availability of nursing positions, rehabilitation services are not necessary. In the jurisdiction in which this matter transpired, there are no legislative guidelines regarding a workers' right to placement services if they are medically stable and are perceived as having transferrable skills for a job which is believed to exist in a reasonable quantity. Nor is the definition of the purpose, process, or standards for a Labor Market Survey defined.

Employment was not secured by the nurse through a non-sophisticated personal job search of approximately six (6) months. Plaintiff's attorney then engaged a Certified Rehabilitation Counselor to perform an evaluation of employability and placability. The rehabilitation counselor indicated the nurse was both employable and placeable. The rehabilitation variables of a thirty - pound lifting capacity, and below average English speaking ability were cited as cause to initiate a self-directed job search program supervised by a rehabilitation counselor to identify appropriate work settings and facilitate securing employment.

Rather than funding the self-directed job search, a non-certified rehabilitation counselor employed through the captive rehabilitation company was asked to contact employers and determine "what opportunities might exist for a registered nurse with the medical restrictions as stated on the report (sedentary or 30 pounds or less of weight restrictions)."

What followed was an individual contacting hospitals, blood banks, nursing homes, health companies, and doctor's clinics that were advertising positions available asking, Do you have positions available for a registered nurse with a thirty pound lifting capacity?

Fifteen (15) companies were contacted, and as would be expected, given the Americans With Disabilities Act, and other pertinent legislation, most gave affirmative answers.

The ethics related to the above matter may appear obvious, but they point to how external influences along with the motivation and ethics of people in control of purchasing rehabilitation services can effect the outcome of rehabilitation activities.

It is unfortunate, but it appears the request for service in this matter most likely was, produce a Labor Market Survey which will show there are jobs for a registered nurse with a thirty pound lifting capacity.

It may also be reasonable to believe the person producing the Labor Market Survey was not provided the evaluation and recommendations produced by the Certified Rehabilitation Counselor.

Ethical Questions/Concerns

Was the Certified Rehabilitation Counselor ethical when recommending placement services for an apparently employable and placeable individual?

Should rehabilitation counselors demand all information related to the matter they are addressing, no matter how specific the request for service?

Was the captively employed rehabilitation counselor ethically bound to point out that placement services may assist and expedite employment?

Should insurance companies be able to direct the services of their captive rehabilitation companies?

Absent legislation defining standards of practice what ethical guidelines should rehabilitation professionals follow?

What are the ethics and objective standards involved in producing a product that would be called a Labor Market Survey?

The general purpose of a Labor Market Survey is to clarify information about the availability of a type of job, for example, registered nurse.

If possible, the Labor Market Survey should determine as much of the following outlined information as possible.

1. Does the job exist in a quantity large enough to make it a viable job goal?

2. What pre-requisite skills are necessary for employment?

3. Who hires registered nurses?

4. What are the wages and benefits associated with registered nursing positions in different job settings?

5. Are there positions available now for registered nurses, and does it appear thee will be in the future?

6. What are the essential physical demands necessary to perform the job functions.

A more specific or singular purpose may be requested, such as to determine the wage range of registered nurses. This in and of itself may not seem unreasonable to do. The ethical dilemma is related to the purpose of the Labor Market Survey, as defined and utilized in the example above, and how it may pre-determine the process, content, and orientation of the Labor Market Survey.

Ethics Questions/Concerns

Are the rudimentary thoughts outlining what a Labor Market Survey is here, ethical or objective enough?

Who should determine what a Labor Market Survey is?

Who should determine how a Labor Market Survey is conducted?

How ethical are any of the activities stated?

Another example of ethical concerns related to who is the client and what is ethical activity by a number of professionals is addressed in the following outline of rehabilitation variables: a thirty-five (35) year old forklift truck driver/warehouse laborer with a diabetic condition and extensive computer skills, severely strained the right ankle. Reflex Sympathetic Dystrophy ensued.

Subsequent to referral to a rehabilitation counselor, and limited progress being made, deterioration occurred. Evaluation by a prominent Anesthesiologist and Pain Management Specialist, determined an electric wheelchair would be needed for an extended period of time, and the cause was either Diabetic Neuropathy or Reflex Sympathetic Dystrophy.

Upon learning this information the worker compensation carrier denied payment for the wheelchair. The individual requested the health benefits carrier purchase the wheelchair, and was told insurance coverage had lapsed.

When the doctor learned from the individual that both sources denied funding to purchase the wheelchair, a new report was written. It stated the electric wheelchair was necessitated by Reflex Sympathetic Dystrophy with the assumed purpose being that worker compensation benefits would then apply.

The rehabilitation counselor recommended evaluation by an independent endocrinologist to address the issue of cause and pursued alternate funding sources for the wheelchair in case insurance benefits would not be available. The worker compensation insurance carrier terminated the services of the rehabilitation counselor, and maintained the position of not purchasing the wheelchair.

In the jurisdiction where this applies, there is disputed case law regarding whether the individual or the insurance carrier has the right to choose the rehabilitation counselor providing service. That being the case, the individual and plaintiff's attorney requested the rehabilitation counselor proceed with rehabilitation services.

Ethical Questions/Concerns

Ethically, what should the rehabilitation counselor do?

What are the ethical concerns for the rehabilitation counselor related to the rights of the individual, anesthesiologist, insurance company, and plaintiff's attorney?

These two examples also lead to the following:

Ethical Questions/Concerns

Can we define what rehabilitation ethic's are?

Can we legislate morals or ethics?

Can we stop short-sighted people from controlling claims cost through purchasing inappropriate, inadequate, misdirected or unethical services? What actions are we ethically bound to take under these circumstances?

Can we hope "bad rehabilitation" will suffocate itself or ethically are we bound to some form of action?

These questions, and those raised throughout this work, point to the lack of clear understanding in the current market-place of what constitutes ethical rehabilitation counseling practices.

Promoting what may hopefully become a self-fulfilling prophecy, and returning to the definitions that began this chapter, it becomes important to realize the terms "moral" and "ethical" need to define for us as rehabilitation counselors, an orientation, a spirit, and an attitude that directs the activities we provide as practitioners, to the individuals in need of our services.

This orientation should motivate us to answer these difficult ethical questions as best our knowledge and ability allows, and also promote the educating of consumers and associated professionals in the purposes of rehabilitation being the provision of objective, positively motivated, and goal-oriented rehabilitation services.

For Your Information

Switzer Scholar Tim Field has noted the following in a special report that he is preparing for publication in late 1993.

Ethics in Rehabilitation

The profession of rehabilitation has evolved so rapidly in the last two decades that it is virtually impossible to the movement within a single dimension. For instance, "vocational rehabilitation" which was defined primarily by the state/federal program has often been considered the "mainstream" for rehabilitation. While the state/federal program has remained fairly stable in terms of regulations and policy and procedures regarding case practice, other segments of the profession have been expanding in a variety of directions.

The most notable areas of activity have been in the private sector of rehabilitation which would include services offered by any vendor through insurance funding. Private rehabilitation companies have formed to provide services to state workers' compensation programs, including such programs as federal employees, longshore workers, coal miners and others. Services providers have included professions from the fields of education and rehabilitation, nursing, occupational therapy, physical therapy, and most recently, case management. As each new group enters the rehabilitation movement there invariably will also emerge a new organizational group and a new code of ethics (usually associated with a new set of standards for performance). As a result, the rehabilitation profession is now blessed (or encumbered) with several ethics standards statements all of which serve as a guide for professional practice. Some of the organizations that have drafted ethics statements are:

- **National Association of Rehabilitation Professional in the Private Sector**
- **National Rehabilitation Counseling Association**
- **American Board of Vocational Experts**
- **American Nurses' Association**
- **National Board for Certified Counselors**
- **American Counseling Association**
- **Certified Insurance Rehabilitation Specialists**
- **National Association of Social Workers**
- **National Forensic Center**
- **American Psychological Association**

The reader is encouraged to consult with the appropriate organization for further information regarding a statement of ethics for specific areas of practice. Obviously, the reproduction of each of these statements would be prohibited by space in this publication.

(Eds. note: Special thanks to Tim Field for sharing this information prior to publication of his forthcoming text.)

Ethics in the private rehabilitation sector is a difficult and important issue. The examples cited by Mr. Steffan are valid and of genuine concern.

Three factors influence the ethical behavior of rehabilitation professionals:

1. Fundamental character of the rehabilitation counselor.

2. Professional training and foundation in ethics imparted by rehabilitation education.

3. Demands placed on the rehabilitation counselor from customers within the private rehabilitation industry.

There is little that can be done to alter the fundamental character a rehabilitation counselor brings to his/her profession. However, rehabilitation education must continue to emphasize professional ethics in the curriculum. As well as providing professional guidelines, actual problem solving practices with ethical dilemmas would be valuable for students to gain a greater level of insight into handling real life situations.

In terms of the issue of unethical demands of customers, I think it is important to note that many insurance companies and other consumers of private rehabilitation services expect and fully support the ethical requirements of the rehabilitation counseling profession. To encourage unethical practices can backfire in the claim administration or judicial process, calling into question the fairness of the claim evaluation process or invalidating the basis on which claim decisions were made.

There is no doubt unethical demands are made on rehabilitation professionals from time-to-time. It appears more needs to be done in educating customers through industry meetings, seminars, etc. on the ethical issues in rehabilitation counseling and the pitfalls to the customer in operating outside of these parameters.

– Catherine C. Bennett

Dr. Steffan's paper on ethical issues in the private sector of rehabilitation accurately points to some of the problem areas that arise in a typical insurance-oriented case, and he correctly draws up a list of concerns that appears to be a combination of ethical issues related to professional practice, and 'non-ethical' issues such as those related to business practice. I personally would have liked to have seen more of an overview article on the topic rather than getting into the finer details of, for example, the content of a labor market survey, which is an inaccurate way of deriving data about the nature and extent of the existing labor market for a person with a disability. Might it not be more useful to ask the question of ***why are we doing labor market surveys in the first place?***

This question alone leads us to the yet broader topic for the field of how did we get forced into doing things we know professionally are of marginal usefulness in the perspective of our work, and how is the data being used or misused by others? In turn, we are then obliged to ask, if it is useful to others and is within the scope of the ordinary practice of their field, such as worker's compensation law, why shouldn't we provide a requested service?

In short, we are again reminded that in rehabilitation counseling we do not work in isolation but rather in contact with many other professions. Our considerations on ethics must thus take into account so many factors that can not be described in a short paper that we must simply take the topic as yet another area that will require continuing discussion over the years to come, oriented toward defining the important areas to be refined over time. Our discussion might better be oriented toward determining the forum for the discussion and helping it take place, and perhaps giving a little time to thinking of how we can make sure that the persons entering our field are well-grounded in an ethical foundation for their lives before they reach us.

– Phillip Bussey

Mr. Steffan has addressed probably the most difficult area and collection of issues in all of rehabilitation. Every association or group that comes along tends to develop, and usually does, an ethics standard statement for their organization and group of members. At this day we have approximately twenty different ethics standard statements by the various rehabilitation counseling associations and allied groups that would have some direct or indirect bearing on the practice of rehabilitation consultants.

As Mr. Steffan has correctly observed, the central issue for private sector rehabilitation is and always has been "Who is the client?" A second critical issues has also been identified by Dr. Gilbride in his chapter with reference to "cost containment".

Who is the Client?

The client is not always the person with a disability or a handicapping condition. In a review of almost any of the ethics standard statements, you will find that the client is indeed identified as the person with the disabling condition, but in practice within the area of private sector rehabilitation that is not always the case. A case in point, is the typical rehabilitation consultant who is hired by insurance to most expeditiously and cost effectively return a person with a disability to work. Other interested parties include, of course, the worker who is injured, the employer, the attorneys (if any), and the rehabilitation consultant him or herself. All parties have a vested interest in the alleged rehabilitation process and further more, all parties have a legitimate role to play. In my view, the "client" should be perhaps identified as the process that involves all of the parties for the most

equitable resolution of issues involving injuries in the work place.

Cost Containment

The containment of rehabilitation costs is a major problem and is contributing heavily to the redefinition of the private sector as we know it today. For instance, California is seriously considering putting further caps and financial constraints on private sector rehabilitation consultants (and companies) as a means of reducing and controlling the exorbitant cost of the workers compensation program. While I strongly feel that the rehabilitation community has taken unfair hits with respect to the spiraling cost, it is also true that the private sector community has done a very poor job substantiating the cost benefits of providing rehabilitation services for the injured worker. At the same time, there have been abuses within the private sector group with respect to double billing, unfair billing, and other related questionable practices by the rehabilitation consultant. Related to this development, many states have and will continue to move away from the concept of mandatory rehab which is viewed as a major component in contributing to the high costs of rehabilitation and workers compensation. In this instance, the "client" becomes the workers compensation fund that is being assaulted by exorbitant costs. Until remedies are found in the cost containment area, some workers who are injured will suffer from the lack of adequate services.

– Tim Field

The issue of ethics is a topic which surfaces often in the private for-profit rehabilitation sector. Everyone seems to have their own ideas regarding what is and is not ethical behavior. It was interesting to see that Mr. Steffan began his manuscript with a dictionary definition of the terms "ethics" and "moral" in an effort to provide a common frame of reference for the reader. Despite the well-established dictionary definitions, there still exists different perceptions of what is considered ethical behavior in the field of rehabilitation. It is easy to understand this confusion given the number of professional codes of ethics which exist within the rehabilitation community. In addition to rehabilitation counselors, vocational evaluators, two different groups of private sector professionals, occupational therapists, physical therapists and case managers, among others, have their own set of ethics.

While the adversarial nature of insurance rehabilitation tends to promote what might be perceived as unethical behavior, rehabilitation professionals need not succumb to such unprofessionalism. Their opinions related to choosing "a side" do not and should not be bought for a fee. Objectivity is still a valued commodity in private for-profit rehabilitation. Communicating this objectivity in a clear, concise manner through educating related professionals and consumers about the purpose, process and outcome(s) of good rehabilitation practice is one of the keys to promoting ethical behavior.

Although some individuals reading the examples of ethical dilemmas in this manuscript may view these situations as unethical, others will disagree and say it is a honest, objective difference of opinion. We need to be able to clearly recognize when differences of opinion are considered unethical behavior and when they are viewed as honest, objective opinions. Perhaps a monograph or case studies book on ethical dilemmas and ethical behavior in rehabilitation might be developed to include all of the rehabilitation professionals involved in the private sector. This publication could include such examples as the ones in this manuscript with responses to specific questions and concerns following each case. Before any effort is made on such a project, it would be beneficial and necessary, as the author points out, to define ethical and moral behavior in rehabilitation in terms of "...an orientation, a spirit, and an attitude that directs the activities we provide as practitioners, to the individuals in need of our services." This may be a major, but necessary, undertaking.

– Juliet H. Fried

There is little doubt that ethics have received a great deal of attention in private rehabilitation. Steffan suggests that a central cause of ethical dilemmas in workers' compensation rehabilitation is the adversarial system. Often rehabilitation providers are hired not to provide services or give an independent opinion, but rather to help one side develop its case against the other side. While an attorney is expected and required to be an advocate and present information in the most favorable light in an attempt to win, this behavior is generally viewed as unethical by rehabilitation providers.

The adversarial system, while not always aesthetically pleasing, is generally regarded as the best method to reach a just conclusion. Perhaps many of the ethical dilemmas that rehabilitation professionals encounter have more to do with disclosure than with morals.

For example, rehabilitation professionals have training and expertise in understanding the impact of disability on employment. If an attorney wants to buy that expertise to develop data to support his/her case perhaps that is OK. The problem may come because rehabilitation professionals portray themselves as neutral when in fact someone in particular is paying their bill. Maybe we should explicitly develop two types of forensic rehabilitation. Type one is based on active advocacy and is paid for by one party. Type two is actual expert testimony, it must be paid for by both parties, and it is expected to be objective and neutral.

– Dennis Gilbride

"Thought provoking" would be the best way to describe Mr. Steffan's paper. "Ethics", this abstract and intangible word will no doubt be the central focus for private sector rehabilitation for many years to come. Yet

this hot topic must be addressed by this profession and industry. For many states, ethical concerns have produced licensing bills or credentialing procedures for rehabilitation practices. Debates will go an forever whether licensing or credentialing will produce better rehabilitation, or better practitioners.

Few things are clear: 1) Rehabilitation is not an exact science; 2) Ethical does not necessarily equal maximal potential, particularly rehabilitation in disability benefit programs and forensic rehabilitation; 3) Unlike other professions, there is no strong "peer review" process in our profession; 4) There are few if any malpractice lawsuits against rehabilitation practitioners.

Recommendations: Rehabilitation education programs must address ethics in their curriculum to raise students' ethical consciousness. Rehabilitation professional associations must make ethics an agenda including the establishment of an Ethics Committee and the incorporation of regular training workshops. Commission on Rehabilitation Counselor Certification (CRCC) should include ethics as one of the certification maintenance requirements. Lastly, practitioners in private rehabilitation need to recognize that they are advocates for the rehabilitation process.

– John W. Lui

I am in full agreement with the author's initial assertion that a majority of persons employed within the private sector make an effort to work ethically within the system in which they practice.

I have heard the question "Who is the client?", and have never had a problem answering that question: the client is the RECIPIENT of our services (either vocational or medical case management), and the customer is the PURCHASER of our services (either vocational or medical case management). All of our rehabilitation efforts should be directed towards obtaining quality, cost-effective services to help the client return to their pre-injury or illness lifestyle. Our customer (the insurance company, for example) is expecting us to bring a case to resolution as quickly as possible -- the least costly, the better. It is the responsibility of the rehabilitation professional to educate our customers that cheaper is not always the least costly way to go when dealing with work-related injury. It is also the responsibility of the rehabilitation professional to educate the client as to the importance of their assumption of an active role in the rehabilitation process.

The service that we offer to our customers needs to be professional, accurate and the same no matter who is purchasing the service. However, I know that in the "real world", the desire to keep a customer happy... and coming back, can sometimes override a professionals' best judgement. However, the issue of ethical dilemmas obviously is not simply a "private rehabilitation" issue, but one that permeates the entire rehabilitation field. For example, how many times is the judgement of a facility-based rehabilitation counselor overruled (or ruled) by an administrator who is trying to maintain a fee-for-service income level, and admits into the rehabilitation program an individual who would clearly benefit from a more appropriate setting or service?

While a Code of Ethics for rehabilitation counselors exists, there needs to be a significant increase in the time and attention paid to this issue both in rehabilitation counselor training programs and by in-service training. As a condition of CARF accreditation, facilities should have to document regular staff and management training sessions int he area of ethics. Certification bodies should require that a certain percentage of certification maintenance credits be devoted to ethics. Private rehabilitation companies should be up-front with potential customers by marketing their services as professional and ethical. The professional associations (NRCA, ARCA) need to regularly offer to its' members professional, practical training on ethics.

– Patricia Nunez

Edward Steffan's paper challenges rehabilitation counselors in the private sector to clearly define ethical practices in order to improve the quality of service delivery. He promotes the underlying basis for this definition as a positively motivated orientation in the provision of objective goal oriented services. Implicit in his essay is the fundamental understanding that educating consumers and professionals about the purpose of rehabilitation first requires that rehabilitation professionals understand their own purpose.

Through the use of case examples, Mr. Steffan raises more questions about what constitutes ethical rehabilitation practice than can be addressed in either his essay or this review. There are however, two questions which are essential to Mr. Steffan's paper. These are whether rehabilitation ethics can be defined and whether morals or ethics can be legislated.

Rehabilitation ethics have been defined. Essentially, the issue is whether rehabilitation counselors, regardless of their sector of employment, elect to act in an ethical manner. Morals or ethics cannot effectively be legislated. However, standards of conduct or behavior can be regulated and enforced. Regulation and enforcement requires a uniform standard of conduct which is independent of funding and a central authority to address complaints.

Addressing the complexity of ethical issues will require a comprehensive approach including training, professional organization support, public relations and legislation.

– Stephen A. Zanskas

Seminar Recommendations

Chapter Five

The following is a summary of the recommendations and implications for action as they relate to the discussion of chapter five. These recommendations were developed by an individual work group and the style of presentation reflects their own format along with implications for action.

The following recommendations and implications for action address ethical issues confronting the field of rehabilitation and rehabilitation providers. The recommendations call for the focus of rehabilitation to be the individual with a disability, emphasizing an individual's dignity through choice. Ethical issues and dilemmas are inherently difficult to address as a topic since they arise throughout individual and organizational decisions, policies and actions regardless of the source of funding. Proactive leadership is required by the rehabilitation community to promote and enforce ethical behavior. Development of a uniform code of ethics for all rehabilitation providers is essential to this process.

Service Delivery

1. The focus of the rehabilitation process must be on the individual with a disability.
2. Rehabilitation providers, their professional associations and certification bodies need to develop a uniform ethics code.
3. Rehabilitation providers should only provide services within the scope of their training and expertise.
4. Testimony, when required, shall be provided objectively.
5. Rehabilitation providers need to understand and actively seek to influence the laws in their jurisdiction.
6. Rehabilitation providers need to use descriptions of behavior rather than judgmental language or labels when communicating about the individual participating in services.
7. Rehabilitation providers should be guided in their practice by the concept "primum non nocere", (i.e. above all, do no harm).
8. Broaden the outcome measures used to assess the efficiency and success of rehabilitation services.
9. Individuals should be allowed to choose their own service provider.

Training

1. The Rehabilitation Services Administration (RSA) and the Council of Rehabilitation Education should require curriculum expansion to include a specific course in applied ethical decision-making. The process of ethical decision-making should be incorporated throughout the curriculum.
2. Applied ethical decision-making should comprise 10% of the total number of continuing education hours required for credential maintenance by each of the respective certification organizations.
3. Employers need to provide inservice training on ethical decision-making as a process.
4. Employers of rehabilitation practitioners need to provide appropriate levels of training and supervision to employees prior to their engaging in practice and throughout their practice. This should include a mentoring process by an experienced professional.
5. Professional organizations, certification bodies, and individual service providers need to proactively educate the public (i.e. the referral source, the individual with the disability, employers, the payor, and other professionals) about the purpose of rehabilitation, standards of ethical conduct and the grievance or complaint process.
6. Curriculum changes are required to include the techniques of professional consultation in order to improve professional interactions.
7. Professional organizations such as the National Rehabilitation Association (NRA), and its divisions need to expand their training opportunities available to their members.
8. The National Rehabilitation Association should conduct a Switzer Memorial Seminar on ethical issues confronting the field of rehabilitation.

Policy or Program Development

1. Discussion of rehabilitation services should focus on the rehabilitation process rather than setting, funding source or other external variables.
2. A "Bill of Rights" should be developed and provided to the person with a disability at the time services are initiated and implemented. Minimally, this document should include: the provider's ethical code, address the issue of privacy, and explain the complaint or grievance process.
3. A central registry or credential for rehabilitation providers/practitioners should be developed. Board specialization would fall within this main credential.

Research

1. The effectiveness of the ethics training package developed by the grant from the National Institute on Disability and Rehabilitation Research (NIDRR) should be evaluated in proprietary and non-profit rehabilitation settings.
2. Research appears indicated on the interaction of the ADA and privacy laws and the implications of this interaction on the provision of rehabilitation services.
3. Additional research is required to identify both "hard" and "soft" outcome measures of rehabilitation services efficiency and success.

Legislation

1. Rehabilitation providers and their respective professional associations need to proactively advance appropriate legislative initiatives or reforms on a local, state and federal level.
2. Rehabilitation providers and their respective professional associations need to become proactively involved in the credentialing movement.

Special Invited Paper

The History of Private Sector Rehabilitation

Lloyd M. Holt

The emergence of any new field is generally the result of concomitant changes occurring in related fields. To understand the origins of private-sector rehabilitation, we need to understand the dynamic changes which occurred in the insurance industry and resulted in the, need for private rehabilitation case management services.

The insurance industry faces its own business cycles which are not dissimilar to economic cycles. There are times when premium income is insufficient to cover the dollar amount of claims and administrative expenses. When this happens, insurers have to draw upon investments for solvency. Another common practice during such times is to reduce operational expenses. The 1960's and 1970's found many insurers making significant operational changes to reduce costs, such as, disposing of company cars for claim adjusters and resorting to telephonically recorded statements from insurance claimants. This resulted in appreciable savings in operational expenses but the loss of personal contact created a vacuum for individuals who were injured or encountered a significant disability.

During this same time, claim losses were accelerated by: 1) competition between health and disability insurers, 2) liberalization of Worker's Compensation laws, 3) the development of auto no-fault legislation, 4) the start of the "liability crisis". A discussion of these events follows.

Competition: Health insurers expanded or developed products issued to employees (group insurance), members of professional associations (group franchise insurance) and through individually underwritten contracts; examples include medical, major medical and hospital indemnity coverage. Disability coverages defined "total disability" as the insured person's inability to perform each and every duty of "his other occupation"(regular job) for a period of two years; thereafter, total disability was defined as the inability of the insured (person) to perform "any occupation"for which he/she was reasonably qualified by education, training or experience. During the 1960's and 1970's the "his occupation" definition of total disability was expanded from two years to five and even seven years. The "any occupation" definition which had previously been limited by short term contracts found liberalization when contract lengths were increased to "lifetime" accident benefits and sickness benefits payable to "age 65".

With these increased contract lengths, insurers started adding "rehabilitation clauses" which basically integrated wages paid with disability payments to those individuals attempting return to work. These clauses were seldom used since few claimants sought jobs on their own and fewer still found their way into the state vocational rehabilitation system. Without private sector case management, these claims continued uninterrupted. In group contracts which reduced benefits for individuals receiving social security disability payments, no one was available to help the individual either qualify for social security benefits or demonstrate that return to work was possible. The system needed case management services.

Liberalization of Worker's Compensation Laws: By the early 1970's, workers compensation benefits in many states were insufficient to cover lost wages. In addition, some states even had maximum "healing periods" after benefits were paid to the expiration of the healing period (often around one year) the claim was settled or the medical benefits were held open so that future medical bills for treatment of the compensable injury could be paid. With the labor movement, worker's comp laws found healthy increases in benefits and the elimination of "healing periods". States started looking more at the welfare of claimants at time of settlement..."was there a job to go back to"? Some states thought this question was so important that "mandatory voca-

Lloyd M. Holt, CIRS, is Coordinator, Patient & Public Information for the Younker Rehabilitation Center, Iowa Methodist Medical Center in Des Moines, Iowa. He is the 1993 President of the national Association of Servcie Providers in Private Rehabilitation (NASPPR), Division of the National Rehabilitation Association.

tional rehabilitation" under worker's compensation emerged in states such as California which passed AB760 in 1976. Similar laws appeared in Georgia, Pennsylvania, Washington State, Minnesota, Colorado and elsewhere.

In the mid 1970's, many states which had given the employer (insurance company) the right to choose the attending physician for the injured employee suddenly relinquished that authority and gave the right of choice to the injured employee and/or attorney. This accentuated the need for medical case management services.

Auto no-fault legislation: Several states developed comprehensive no-fault automobile insurance laws. Michigan was one of the early leaders; this law initially provided: 1) unlimited lifetime medical benefits for treatment of injuries, 2) wage loss replacement of up to $1,000/month for up to three years, 3) the ability to sue the party at fault only if the injured party had a permanent disfigurement, a permanent loss of a body part/function, or death of the injured party. Similar comprehensive auto no-fault laws appeared in Pennsylvania and a few other states, but most states utilized a more conservative system designed to expedite handling of small losses while allowing large losses to revert to typical tort liability handling. In those states with comprehensive no-fault coverage, medical case management flourished and vocational rehabilitation work increased.

The liability crisis: This had its roots in the 1960's and 1970's when medical malpractice awards skyrocketed. Where liability seemed restricted by monetary policy limits, there suddenly began a trend toward increased product liability suits and related contingent liability actions. Since liability settlements looked at both medical expenses paid and wage losses incurred, private rehabilitation case managers were called upon for expert opinions on issues such as a person's employability, and lifecare planning issues related to a person's future medical expenses. The entire "forensic rehabilitation" area advanced as healthcare costs soared, and a new form of case management was needed.

In a previous Switzer Seminar paper, John J. Benshoff gave George T. Welch the credit for founding private-sector rehabilitation in 1970 within a unit of INA (the Insurance Company of North America which was later to merge with Connecticut General and be known as CIGNA). INA/CIGNA had been using rehabilitation nurses for several years prior to 1970 in many of their larger offices. Their job included medical care coordination, medical cost-containment and vocational rehabilitation long before the terms became fashionable! Those of us who worked for (and with) George Welch in the early days of private-sector rehabilitation understand that his talent was in making rehabilitation consulting services a fee-for-service business (in Welch's terms, "blending a business with a profession").

Welch launched International Rehabilitation Associates (later to be called Intracorp) in May, 1970. Most of the initial case managers were nurses who provided medical case management services, ensuring that each person received the best medical care available to mitigate the claimants injury. These nurses were also called upon to provide direct job placement services and were quite successful. Most of all, these nurses provided excellent case control at a time when it was desperately needed and not being furnished by insurers or anyone else. Rising benefit levels and liberalization of laws previously outlined complimented this need and enhanced the success of this beginning.

In 1975 vocational rehabilitation by master credentialed counselors started gaining popularity. Many nurses did not feel totally comfortable with vocational cases and felt they needed better vocational supervision. With the passage of AB760 in California mandating master credentialed vocational involvement and with the emphasis being placed on vocational outcome in non-mandatory jurisdictions, vocational rehabilitation emerged as another critical facet of the case management process.

Although some may think that rehabilitation started in Worker's Compensation, the pioneering efforts actually had their origins in the liability arena. (My introduction to rehabilitation was in 1969 at the Health Insurance Association of America annual meeting in Boston. One of the sessions was on rehabilitation and showed a movie "The Rehabilitation of Bob Burgeon" a movie made by INA which showed how extensive medical and vocational rehabilitation was used to greatly enhance the life of a liability claimant while actually saving the insurance company money---a true WIN-WIN scenario). If utilizing rehabilitation were to prove its effectiveness as a humanitarian, cost-effective process, its higher costs had to demonstrate its worthiness in mitigating losses and reducing claim settlements. This was best documented in the liability area. Worker's Compensation became the primary source of private-sector rehabilitation because there was never a doubt over who was liable and to what extent.

Even George Welch would be the first to admit (as he did to me many times) that he was not the founder of the concept of merging rehabilitation with insurance claim handling. Welch frequently spoke of one of his own heros - the late Arne Fougner who wrote and spoke prolifically to his fellow professionals in the insurance industry from 1948 until his untimely death in 1965. His message was loud and clear in pushing for a change in how his industry perceived auto accident "victims" and its reluctance to accept rehabilitation with its emphasis on the positive - "what remains" rather than "what's lost" (what functions are impaired, how much earning power is reduced, etc.). Fougner, the pioneer in viewing the integration of rehabilitation in liability coverages said "acceptance and application of rehabilitation precedes settlement. Rehabilitation is designed, not to settle an argument but to solve a problem. By solving the medical problem - or, at least, arresting, "fixing" and reducing it - the legal argument should be more clearly defined, being sharply reduced". Fougner said this in early 1962 - well before rehabilitation case management (either medical or vocational) came to the forefront in the private sector.

Today, we are confronted with challenging issues - health care reform, Worker's Compensation reform or the adaptation of "24 hour coverage", and, the potential for placing a

cap on medical malpractice awards. May we as a society never forget the struggle undertaken by these pioneers to prove that rehabilitation is beneficial for claimants and society while saving insurers money. Perhaps the day will soon come when we evolve into a new line of thinking - such as that uttered by Arne Fougner on January 25, 1962 before the New York State Bar Association Insurance Section - "we must free ourselves from the habit of thinking exclusively in terms of money as the sole means to settle arguments and to solve problems. In the entire (claims) process, lawyers and insurance representatives have been satisfied to act the role of mercenaries, and this in a field of disaster where the cries are loud and clear for Samaritans"! We remain optimistic to see the development of a new unified system of insurance which will delete the notion of excessive monetary gain and incorporate the critical elements of medical and vocational rehabilitation case management. It is best for the claimant, best for the payor, and best for society.

Special Invited Paper

Choice, Autonomy and Individual Provider Selection

Stephen A. Zanskas

Empowerment of individuals with disabilities through choice and control of services has developed as a focus of rehabilitation. The development of these themes as trends in our society is reflected by the civil rights nature of rehabilitation legislation. This trend began with the civil rights aspects of Sections 503 and 504 of the Rehabilitation Act of 1973 and their prohibition on employment discrimination against individuals with disabilities by federal contractors.

Consumer control of services has conceptually been advanced by the independent living movement. A movement created by the Reauthorization of the Rehabilitation Act in 1978. Passage of the Fair Housing Amendment Act, Air Carriers Access Act and the Americans with Disabilities Act reflect our society's desire to further empower individuals with disabilities (NCIL, 1991).

Choice, simply defined, is the act or power of choosing. The power to independently make a choice among alternatives and exercise one's choice requires autonomy. Choice and autonomy reflect the quintessential aspects of human dignity. Qualities long denied individuals with a disability when selecting a rehabilitation counselor or other service provider. The denial of these aspects of human dignity represent a fundamental structural paternalism in the provision of vocational rehabilitation services and the ultimate act of discrimination.

Evidence of this structural paternalism is found in the 101st Congress' Conference Report on the Americans with Disabilities Act of 1990. Among the congressional findings is this powerful statement:

"individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to society."

Individuals with disabilities alone or with their representative possess the ability to make independent informed choices regarding whether a provider's education, experience, expertise qualifications meet their unique needs. However, individuals with disabilities, with few exceptions, have been precluded from making an independent, informed choice regarding which counselor's or provider's education, experience, qualifications or expertise would most likely meet their unique needs. Rather, individuals with disabilities have been assigned to "professionals" by geographic location, agency contractual relationships, "disability" or referred by third party payors without being advised of the existence of alternatives. It is not that individuals with disability, their family members, or representatives are unable to arrive at informed decisions, rather, lack of choice in the selection of a provider appears to be structural and a function of economics. Services for individuals with disabilities are often purchased by the tax payor or an insurance carrier. Reliance upon third party payors and their concerns for economy or other measures of success is not always consistent with individual development. Individuals with disabilities need to control the method of payment, whether by voucher or some other system to obtain equal status in our society.

Structurally, rehabilitation counselors and other rehabilitation providers require independence from the potential for conflict between the values of the purchaser of services and the individual who presents for services. Managed competition of rehabilitation professionals would establish a market place of individual providers for consideration and selection by an individual with a disability. No longer restricted to an agency, contractual relationship or third part

Steve Zanskas, M.S., C.R.C., C.P.C., Crawford & Company, Healthcare Management, Green Bay, Wisconsin

preference, the individual with a disability could freely choose their service provider.

To ensure quality and equal opportunity for selection, the managed marketplace of rehabilitation professions would require a central registry of professionals, subscribing to a uniform code of ethics, providing enforcement for ethical breaches and/or legal violations and a method of payment presented by the participant in services.

Debates regarding whether an individual with a disability prefers to be considered a client or consumer are moot when the person lacks autonomy and choice. Lack of choice relegates individuals with disabilities to the second class status of a recipient.

Our culture has promoted self-determination. The mere existence of a disability does not eliminate that expectation. Managed competition regardless of whether an individual receives services as a benefit or entitlement would empower individuals with disabilities to choose a rehabilitation professional. Choice and autonomy are fundamental aspects of human dignity and empowerment. Extending the right of choice in the selection of a rehabilitation professional to individuals with disabilities would convey as a society the recognition that individuals with disabilities do not require paternalistic protection based upon stereotypic assumptions.

Paradoxically, the systems which developed to enable individuals to attain independence, civil rights and the choices which currently exist can now be perceived as representing the barriers for attaining these same goals.

References

Conference Report, Americans with Disabilities Act of 1990 (Report 101-596, 101st Congress, 2nd Session, 1990) p. 3.

Position Paper on the Reauthorization Act (The National Council on Independent Living, NCIL, 1991) p. 1-4.

Special Invited Paper

Rehabilitation in Workers' Compensation: A Growth Potential

Bruce Growick

It is a generally acknowledged fact that rehabilitation and workers' compensation are made for each other. In workers' compensation, the problem is an injury which prevents an employee from returning to work, and the solution is rehabilitation which assists disabled workers in returning to work. Workers' compensation is more than just a paycheck for someone off of work, medical doctors for acute care, and lawyers for necessary litigation, it is also about returning injured workers to productive, meaningful activity—a job to return to. Rehabilitation facilities nationwide can play two very important and complementary roles in rehabilitating injured workers: case management and work hardening. The purpose of this article is to describe the different kinds of workers' compensation insurance, and how industrial rehabilitation can help to save both money and lives.

Workers' Compensation is a system of insurance designed to protect employees and employers from the costs of industrial injury. This insurance system is federally mandated but administered by legislative and regulatory groups at the state level. Each of the fifty states has created a patchwork of laws and regulations governing their workers' compensation. Although this can be confusing to risk managers who must administer workers' compensation benefits in several states at the same time, it has allowed states the freedom to tailor their workers' compensation systems to fit the needs of their own workers and employers.

For this reason, it is important for rehabilitation specialists to understand and appreciate the different benefits and services which are "allowed" in their state, and also how workers' compensation insurance is administered from state-to-state. From knowing what rehabilitation services are authorized, and how employers have obtained their workers' compensation coverage, rehabilitation facilities can develop the necessary services which are needed and market them appropriately.

There are three basic types of coverage for workers' compensation: a state operated workers' compensation fund, private insurance companies, and employer self-insurance. Each of the fifty states has at least one of these conduits in place to provide workers' compensation coverage, and most states allow employers a choice among these three coverage formats. The following is a brief description of the three types of insurance coverage.[1]

State Fund Insurance

About half of the fifty states have a state-managed (i.e., public, not-for-profit workers') compensation fund. These funds operate in the same way as private insurance companies, employing claims examiners and adjustors, actuaries and accountants. The state funds offer only workers' compensation insurance, and therefore are considered single line insurance entities. Premiums are paid by employers into the fund, the amount of which is determined by the type of work (e.g., coal miners are probably more likely to be injured on the job than registered nurses), the number of accidents the company has had in the recent past (called their "experience rating", and other factors, such as the number of safety violations which have been reported at the company (i.e., OSHA violations).

Bruce Growick, Ph.D., The Ohio State University

1 For an up-to-date overview of the workers' compensation statute of the 50 states, the District of Columbia, Guam, Puerto Rico and all of the provinces of Canada, please consult the 1992 edition of *Analysis of Workers' Compensation Laws*, published by the U.S. Chamber of Commerce.

These premiums are used to pay for all of the expenses related to resolving a claim including rehabilitation services. If a state has a separate rehabilitation agency for workers' compensation, it is usually expected that an injured worker will be served through that program whenever possible. If no state industrial rehabilitation agency exists, then injured workers are typically referred to private rehabilitation companies which arrange for services (i.e., case management) necessary to return an employee to competitive employment. Until that injured employee is returned to competitive employment, an outstanding liability exists for the state fund.

Private Insurance

Many states prefer to have private insurance companies write workers' compensation insurance for employers. The belief here is that competition among the insurance companies will lower the premiums employers will have to pay. Once again, premiums are based upon the safety history of the company and the inherent risk factors involved in the company's particular kind of work.

Rehabilitation services, in states where private workers' compensation insurance can be "written," is usually performed by private rehabilitation companies. Rehabilitation companies compete for new referrals of industrially injured workers from private insurance companies. Once again, the outstanding liability is not removed until the injured employee has returned to work or the case has been settled. The ten largest private workers' compensation writers are indicated in Table 1.

Self Insurance

An additional alternative, somewhat unusual and quite different form those previously discussed, is employer self insurance. In this mode of coverage, the employer sets aside a certain percentage of the company's profit into an escrow account which can be used only to pay for workers' compensation costs accrued by the company. An advantage of this plan is reduced insurance costs to the employer, since there is no actual "premium" to be paid. If no injuries or accidents occur on the job, then the employer does not forfeit any money, as would be the case if a regular premium had to be paid to an insurance company or state fund. On the other hand, the employer must be able to spare a modest amount of profit to place in this account to cover all possible claims. For this reason, self-insurance is chosen mostly by very large corporations in states where it is a legal coverage alternative.

Rehabilitation costs are likewise the responsibility of the company. However, the self-insured company has total freedom in securing rehabilitation services for its injured employers. If a state has an industrial rehabilitation agency, the self-insured employer may use those services, but is responsible for all costs incurred. The self-insured company may also opt to choose a private rehabilitation company to provide rehabilitation services to its injured workers. Again, the costs are paid out of the self-insured company fund. Whether the mode of coverage be state fund, private insurance, or self-insurance, employers in growing numbers are looking to rehabilitation services as a means through which workers' compensation costs can be minimized. This realization has caused an explosion of opportunity for rehabilitation agencies and professionals. And there are two important roles that rehabilitation companies can Play: case management and/or work hardening.

Industrial Rehabilitation Services

Similar to other types of rehabilitation, case management in rehabilitating injured workers is a process by which an individualized plan or program of rehabilitation is developed by a rehabilitation professional, and monitored to completion. By working closely with the disabled employee in an active program of rehabilitation, insurers and employers can facilitate an individual's return to work. In the case of successful rehabilitation, the employee once again becomes a productive, contributing member of the work force instead of depending on disability payments.

The 10 Largest Workers' Compensation Writers

The 1990 Rankings as compiled by A.M. Best, an Insurance Rating Organization

Company	1992 Direct Premiums (Billions of Dollars)	1990 Market Share (Percent)
Liberty Mutual Group	$3,772	10.8
CIGNA Group	$2,001	5.7
American International Group	$1,939	5.5
CNA Insurance Companies	$1,870	5.3
Travelers Insurance Group	$1,759	5.0
Aetna Life and Casualty	$1,679	4.8
Hartford Insurance Group	$1,666	4.8
Kemper International Insurance Companies	$1,538	4.4
Nationwide Group	$1,260	3.6
Continental Insurance Group	$1,213	3.5

Table 1

In some states, case managers must possess minimum qualifications before they can develop a rehabilitation plan on behalf of the employer or the insurance company. Most often the rehabilitation professional must be either a certified rehabilitation counselor or nurse. Because every worker with a disability has unique needs, successful industrial rehabilitation relies on an individualized program managed by a well trained rehabilitation professional. Industrial rehabilitation, like most types of rehabilitation, must be viewed as a dynamic process requiring direct involvement and personal attention by the case manager.

When developing a rehabilitation plan for an injured worker, the case manager must take into consideration a client's financial needs and legal rights under workers' compensation in that state. The rehabilitation plan may include medical management, functional capacity assessment, job analysis, transferable skills analysis, job modification, job placement assistance, and even retraining if necessary. Of course, any of these services can be purchased at a local rehabilitation facility if they are available. It is not uncommon, for case managers in workers' compensation, to refer clients for services to the facility in which case managers are employed.

The newest and most used facility-based service in industrial rehabilitation nowadays is ***work hardening***. Work hardening is an individualized, work-oriented activity that involves a client performing simulated or actual work tasks. These tasks are structured and graded progressively to increase psychological and physical tolerance, and to improve endurance and productivity. Work hardening provides a transition between hospital-based care and return to work while addressing the issues of productivity, safety, physical tolerances and worker behaviors. Many work hardening programs are located in outpatient medical facilities, or freestanding rehabilitation centers.

Work hardening can be integrated into other rehabilitation services, such as pain/stress management, vocational evaluation, and career counseling. Work hardening sevices can be provided independently if other components of the rehabilitation plan are completed, or if a client, by virtue of his or her condition, needs only the vocationally reinforcing aspects of work hardening. In either case, work hardening is quickly becoming a vital component of many industrial rehabilitation programs. In fact, work hardening is a new accreditation category used by Commission of Accreditation of Rehabilitation Facilities and is now required in some states for reimbursement by insurance companies.

The basic goal of industrial rehabilitation is to assist injured workers in returning to gainful employment. From a financial standpoint, the employer saves money in three ways when rehabilitation is successful: the overall costs in a claim are reduced; the injured worker returns to work faster; and the amount of workers' compensation the experience-rated employer must pay in future premiums is reduced. In Ohio, an independent actuarial firm conducted a study in 1987 and discovered that more than $25,000 was saved when an injured worker returns to work through rehabilitation. It is obvious that the employer and the employee have a lot to gain by using rehabilitation services.

Conclusion

Workers' compensation and rehabilitation are indeed made for each other. Since the ultimate goal of workers' compensation is returning the injured worker to employment, and vocational rehabilitation is composed of services aimed at employment for people with disabilities, it is only natural that industrial rehabilitation in America has flourished the last 15 years. What rehabilitation has to offer is what employers and insurance companies want for their injured employees-good, cost-effective rehabilitation so that both money and lives are saved.

End Notes

Rehabilitation in the 90'S and Beyond

Barbara Greenstein

The field of rehabilitation has undergone many changes, driven by the perceived needs in the marketplace. The earliest roots are the attempts of communities to support individuals with disabilities; we have grown into numerous professional disciplines. In 1993, we are fragmenting ourselves and losing the focus of our work. In order to plan for the future, we need to take stock of our strengths and weaknesses:

Strengths

1. We know that the individual with a disability is the focus of the rehabilitation process.
2. We have core knowledge encompassing medical, vocational, cultural, legal, and technological issues.
3. We have broad experience with both local and national labor market trends.
4. We have skills that are valuable in many settings besides traditional vocational rehabilitation: medical institutions, the legal system, and business and industry.
5. We are flexible and creative in looking for solutions to the employment problems of the disabled individuals we serve.

Weaknesses

1. We have become fragmented into many tiny disciplines, some of which may have less than 100 practitioners in the entire country.
2. We spend alit of effort "guarding our turf" and defending these tiny disciplines.
3. We do not understand how being accountable for our professional actions is a sign of our maturity as a profession.

As we stand on the edge of the Twenty-First Century, it is important to contemplate how we can build on our strengths and minimize our weaknesses. First we must look at the similarities we share as rehabilitation professionals. Our common core of knowledge crosses all the disciplines where we work, and it is this core that defines our professional identity. We are rehabilitation professionals, not rehabilitation counselors or job placement specialists or vocational evaluators.

Unifying ourselves as rehabilitation professionals means having a single certification by which the outside world can recognize us. As we expand our services into the legal system and business and industry, it is important for these new consumers to have an easy way to know who has the qualifications to perform the desired services.

The issue of accountability has emerged both because of disabled individuals becoming more involved in directing their own rehabilitation programs, and by the expansion into industry. There can be no debate about the rights of disabled individuals to receive high-quality service and to hold the providers accountable for delivering it. In industry, accountability is the norm, from the line worker who must meet production quotas, to the executive who must deliver a certain level of profitability to the shareholders. Accountability does not mean that our professional judgement is being questioned; it means that our profession has matured.

In the future, rehabilitation professionals with expertise in various areas will provide services in many settings: public and private agencies, medical facilities, homes, legal settings, and business. Individuals with disabilities will have expanded opportunities for fulfillment in their lives. Remembering our roots will lead us to the future of rehabilitation.

Dedication

This paper is dedicated in loving memory of Melvin Greenstein (2/28/20 - 2/1/93), my father and mentor. In a distinguished 25-year career in rehabilitation, he served as a staff member of the Chicago Jewish Vocational Service, and as the Executive Director of the Kennedy Job Training Center in Palos Park, IL, and the Orchard Mental Health Center in Skokie, IL. At all times, he sought to bring dignity to the lives of physically and mentally disabled individuals. Rest in Peace.

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Committed to Enhancing the Lives of Persons with Disabilities

At the reception, friends and colleagues of the late Mary Switzer: Joseph Fenton (NIDRR), Deno Reed (RSA & NIDRR retired), Martin McCouitt (RSA & NIDRR retired, S. Norman Feingold (formerly B'nai Brith Vocational Service)

Carl Hansen, Chairperson, Switzer Memorial Committee, introduces Justin Dart, Jr. (Justin Dart, Jr. is the Chairman of the President's Committee on Employment of People with Disabilities, and a chief architect of the ADA.)

Listening attentively at the seminar are scholars, Phil Bussey, Ralph Crystal, Estell Davis, and Tom Davis.

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At the reception. Bill McCahill (recipient of Switzer Award), with Miriam Stubbs (left) (formerly with RSA) and Ann Tourigny, NRA Executive Director

Mark Shoob, Acting Deputy Commissioner of RSA.

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At the reception Charles Harles, Director of INEABIR, and James Galetka, Executive Director of RESNA

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Mary E. Switzer

1900-1971

Few people realize that Mary E. Switzer had a satisfying and fully successful career in federal government employment that spanned several decades prior to her formal entry into the field of rehabilitation. She was fifty years old when she became director of the Office of Vocational Rehabilitation in 1950, and she brought to the position a superior intellect and ability. Her many talents and experiences in economics, the legislative process, government administration, health, welfare and public education were only a few of the composite assets brought with her. She entered the movement at a crucial point in its evolution. It was a time in which difficult decisions had to be made between maintaining the status quo or moving to a larger and unknown future, but with increased opportunity to serve tens of thousands of people with disabilities yet in need.

Following a life pattern in support of increased services to people with a more responsive and humanitarian government to changing human needs, she readily committed herself to the less certain but more hopefully expanded future for rehabilitation. The rest is history. The breadth and humanity of Mary Switzer are stamped forever on the passage of *Public Law 565* with its research and demonstration features, its concern for rehabilitation education, its mandate to construct necessary rehabilitation facilities, its totally new characteristic of international efforts and cooperation regarding rehabilitation, and perhaps, above all, in its expanded funding base for more personnel and programs for those in need of rehabilitation services. In the years that followed, she went on to even greater legislative and governmental leadership heights on behalf of both disabled and disadvantaged people.

Despite the demands on the national and federal scene, her presence was almost ubiquitous on behalf of program development and extended services to needy people. On a regional, state or local level, be it public or voluntary services, if it were in the interest of rehabilitating those in need, somehow, she would "arrange to be there."

The *Who's Who* has chronicled her many national and international awards. Also recorded are her presidencies of many organizations including the National Rehabilitation Association, whose members and their efforts she held in high esteem. But she did not reach the heights of her ability when she was made the first Administrator of the Social Rehabilitation Services, nor when she retired from the position, nor when she became internationally involved in the World Rehabilitation Fund. Instead, she found her greatness when she touched each of us, bringing our full humanitarian efforts and qualities to the fore on behalf of disabled and disadvantaged people. While readily recognized as a truly great administrator in the classical sense, her true capacity and ability can only be appreciated when we realize that these accomplishments sprang from an inner expression of sensitivity, emotional refinement and dedication to serve all less fortunate people. Her egalitarian qualities were not contrived but spontaneous, stemming from love and respect for all living things.

All of us in the National Rehabilitation Association and in rehabilitation, and all people with disabilities, have had better, more meaningful and more productive lives because her presence and her being were sufficiently large to embrace and accept us as we are and help us better understand where we should be.

What more can be said than that we had the joy and privilege of knowing her?

– J. B. Whitten, *Journal of Rehabilitation*, November/December, 1971

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Switzer Memorial Seminars

As a living tribute to the memory of Mary E. Switzer, each year a special topic of vital interest to the rehabilitation of persons with disabilities is explored in depth. One of the outcomes of each seminar is a Switzer Monograph which clarifies the thinking in a given area of rehabilitation and sets goals and objectives for positive action. Those individuals invited to participate in the Seminar are designated as Switzer Scholars

Mary E. Switzer Memorial Seminar and Monograph

To perpetuate the memory of a great woman and great leader in the field of rehabilitation by establishing a memorial that will expand and enrich services to persons with disabilities.

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